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ABSTRACT

This instructor's guide contains 65 lessons designed to aid teachers in presenting a course in basic nursing procedures for students studying for careers as health care assistants. Lesson plans consist of a scope, objectives, suggested supplementary teaching and learning items; references, an introduction, a lesson outline, handouts, evaluation and test items, and answers to test items. The units are organized in 16 units that cover the following topics: interpersonal relationships and the health care team; using communication and observation skills; safety; concepts of microbiology; concepts of the body as a whole; the skin and its appendages; the digestive system; the musculoskeletal system; the cardiovascular system; the respiratory system; the nervous system; the sensory system; the endocrine system; the urinary system; the reproductive system; and understanding the elderly. The guide also contains a resource section listing 43 books, newsletters, and pamphlets and 9 agencies and audiovisual resources; and a glossary containing approximately 600 terms.

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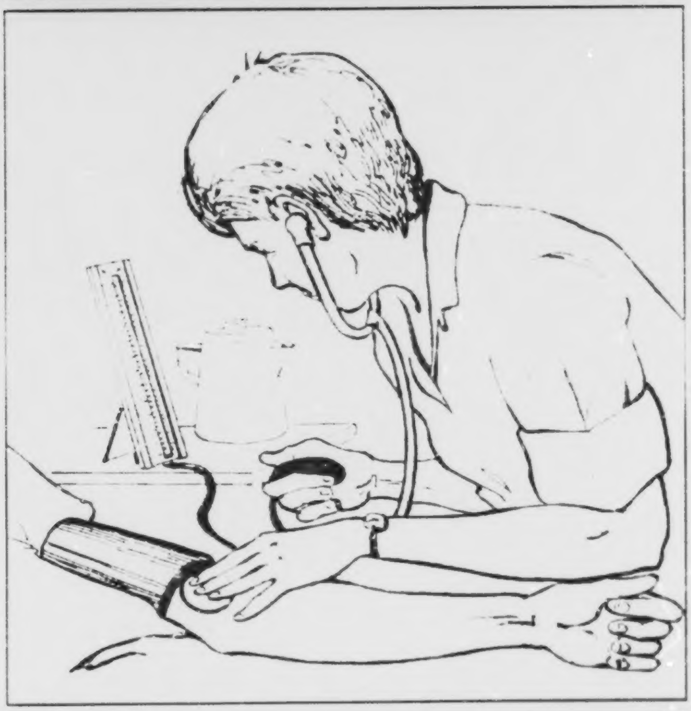
Health Care Assistant

1993



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HEALTH CARE ASSISTANT

Instructor

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HEALTH CARE ASSISTANT

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PREFACE

The first edition of the Health Services Assistant program was completed and published in 1974. In 1984, a second edition was published which differed from the original significantly in that demonstration lessons relating to basic nursing procedures were omitted. It was determined that the instructor could provide appropriate lessons from other curriculum sources, according to each student's occupational interest. As a great number of Health Services Assistant students demonstrated interest in the nursing field, lessons covering basic nursing procedures relating to the 12 body systems were taken from the Nurse Assistant in a Long-Term Care Facility curriculum guide (also published by the Instructional Materials Laboratory). In time, many teachers expressed frustration with having to merge two sources of lesson plans into one curriculum. The table of contents for the HSA guide became virtually useless as lessons from the CNA guide were mixed in.

When the Instructional Management System was established by the Missouri Board of Education, the Department of Elementary and Secondary Education developed guidelines for implementation of the Vocational Instructional Management System (VIMS). Vocational programs responded by identifying competencies in each occupational area that students should master. In December of 1986, an advisory committee composed of health occupations educators and representatives from the Department of Elementary and Secondary Education met to identify the core competencies for Health Services Assistant. Existing competencies from the HSA curriculum were refined and updated, and competencies covering basic nursing procedures related to the body systems were added. The competency list was verified and then published as the Health Services Assistant Competency Profile.

In June 1987, funds were provided by DESE to revise the Health Services Assistant curriculum and to align it with the competencies appearing on the HSA competency profile. The advisory committee met again to perform an instructional analysis, which is the process of rearranging and grouping competencies in a logical teaching/learning sequence and identifying the necessary cognitive information students need to master a skill. The end product of the instructional analysis was the content outline from which this curriculum was developed. The committee consensus was that lesson plans covering basic nursing procedures contained in the nurse assistant curriculum be included to relieve teachers from the task of moving lessons from one guide to another.

The project writer began revising lesson plans from the existing HSA curriculum guide, as well as writing several new lessons (including "AIDS and the Health Care Worker"). Lessons from the revised Nurse Assistant in a Long-Term Care Facility curriculum guide were reproduced and included. The material was then edited and accompanying artwork updated or developed by the Instructional Materials Laboratory.

Funds were again provided in 1988 by DESE for the fieldtest phase of this project. Lesson plans were fieldtested in the classrooms of six vocational schools during the 1988-89 school year. Lengthy fieldtest evaluations completed by each site coordinator were reviewed at the conclusion of the fieldtest and approved corrections/revisions implemented to the final draft.

The 1989 edition of Missouri's Health Services Assistant curriculum guide represented a significant effort on the part of the advisory committee, the writer, and those dedicated individuals who fieldtested it. It was also a step forward for instructors who were implementing VIMS by providing them with curriculum which aligned with the competencies to which they were teaching.

The Health Services Assistant manual contains a number of lesson plans covering basic nursing procedures that are included in the Nurse Assistant in a Long-term Care Facility curriculum guide. Because of changes in federal laws and state regulations governing nurse assistant training, the curriculum guide was updated. It was also necessary to update the HSA manual. Funds were again provided in 1993 by DESE to update the curriculum. Changes in the 1992 revision of the Nurse Assistant in a Long-Term Care Facility were incorporated. Additional information on anatomy and physiology, hepatitis, tuberculosis, and infection control was added. Also, Body Substance Precautions were incorporated throughout the lessons. The advisory committee outlined what needed to be updated and recommended changing the title to Health Care Assistant. The competency profile title will also be changed to reflect the change in the curriculum.

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Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990.

Woodrow, Ruth; Essentials of Pharmacology for Health Occupations, 2nd ed. Albany, New York: Delmar Publishers, Inc., 1992.

Agencies and Audiovisual Resources

Missouri Department of Health
P.O. Box 570
Jefferson City, MO 65102

Film and Literature Library
Missouri Department of Health
P.O. Box 570
1738 East Elm Street
Jefferson City, MO 65102
314-751-6400

MedCom Corporation
P.O. Box 116
Garden Grove, CA 92642
800-877-1443 (Toll Free)

Training Unit
Division of Aging
615 Howerton Court
Jefferson City, MO 65109
314-751-3082

Care Aids, Inc.
8950 Lurline Ave.
Dept. N. 567
Chatsworth, CA 91311
213-341-8200

Concept Media
5024 Lankerskim Blvd.
No. Hollywood, CA 91601
714-833-3347

Media Center
State Fair Community College
1900 Clarendon Rd.
Sedalia, MO 65301
816-826-7100

Missouri Vocational Resource Center
8 London Hall
University of Missouri
Columbia, Missouri 65211
1-800-392-7217 or 314-882-9610

Interactive Health Network
6425 Powers Ferry Road N.W.
Suite 300
Atlanta, GA 30339
404-850-1000

LESSON PLAN: 1

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I : INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

SCOPE OF UNIT:

This unit covers an overview of course objectives and requirements, effective study habits and test-taking skills, the types of health facilities, the members of the health care team and their functions, the role of the health care assistant relative to the health care team, and ethical and legal responsibilities.

INFORMATION TOPIC: I-1 OR DEMONSTRATION:

HEALTH CARE ASSISTANT
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List five objectives of this course.
2. Describe rules and regulations as stated in your student handbook.
3. Identify course requirements as determined by your school.
4. Explain survival tips for students.
5. Match personal appearance qualities of a health care assistant with their definitions.
6. Match essential traits and attitudes for the health care assistant with their definitions.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Essential Attitudes for Establishing Working Relationships with Clients
2. HO 2: Promoting Positive Human Relations
3. HO 3: Poem of Compassion
4. HO 4: Grooming

5. Audiovisuals available from the Missouri Vocational Resource Center
    a. Self-esteem: Know You're Good and Wear it Well, video #R82, 15 minutes.
    b. The Most Amazing Computer of All (Attitude), video #R80.
    c. Keys to Increasing Your Self-Confidence, video #R84, 17 minutes.
6. Audiovisuals available from the Missouri Division of Aging Film Library
    a. We Know You're There - Message From Some Friends, video (TF #43), 25 minutes
    b. Stress, 35 mm filmstrip/cassette (TF #39), 15 minutes
    c. What Do You See Nurse?, video (TF #44), 15 minutes
    d. Self Esteem and Peak Performance, audiotape (TT #37), 6 tapes
7. Television and VCR
8. Tape player

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 1 (Student Reference page 1) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Schniedman, Rose; Susan Lambert; Barbara R. Wander. Being a Nursing Assistant. 5th ed. Bowie, MD: The Robert J. Brady Co., 1989.

Schwartz, Estelle and Lillian Potter. Foundations of Patient Care. Philadelphia: J.B. Lippincott, 1981.

Barbara R. Hegner and Esther Caldwall. Nursing Assistant: A Nursing Process Approach, 6th ed. Albany, NY: Delmar Publishers, Inc., 1992.

Sorrentino, Sheila A. Textbook for Nursing Assistants, 3rd ed. St. Louis, MO: Mosby-Year Book, Inc., 1992.

INTRODUCTION:

In our study of health occupations, we will learn about the different kinds of health care workers and their various skills. We are going to talk about the personal characteristics of health care personnel. We all talk, think, and act in our own particular way, and we all have good qualities. It is especially essential that a health care assistant develop those qualities and attitudes essential to good interpersonal relationships. Health care assistants deal primarily with people; therefore, attitudes and behavior are of particular importance.

LESSON PLAN: 1

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

OUTLINE:

I. Objectives of the Course (II-1)

   A. Explain the interrelationships and the opportunities for careers in health occupations.

   B. Perform on the job the basic entry-level skills of a health care assistant in one or more of the health occupations.

   C. Describe the technical information needed to make judgments in performing health care assistant duties.

   D. Identify the physical, emotional, and spiritual needs of families and clients.

   E. Meet the physical, emotional, and spiritual need of families and clients on a health service assistant level.

   F. Exhibit behavior which indicates an attitude of respect for clients, coworkers, and fellow citizens.

II. Rules and Regulations of Individual School (use student handbook) (II-2)

III. Course Requirements (determined by individual schools) (II-3)

   A. Attendance

   B. Overall grade

   C. Classroom strategies

      1. Overview

      2. Use of student guide

      3. Use of references

         a. Textbooks

         b. Periodicals

         c. Pamphlets

25

4. Audio-visual materials
5. Evaluation items
6. Assignment/activity sheets
7. Tests
8. Procedures
9. Classroom discussion

IV. Survival Tips for Students **(II-4)**

- A. Study habits
  1. Surroundings
     - a. Quiet
     - b. No television or radio
  2. Preview material.
     - a. Read material quickly.
     - b. Use topic headings or key sentences.
     - c. Ask yourself what each paragraph contains.
  3. Read each paragraph.
     - a. Remember to read for content; do not just look at the words.
     - b. State paragraph content or ideas in your own words.
     - c. Underline important words, sentences, or phrases.
     - d. State topic aloud.
  4. Test yourself. Construct your own test questions.
  5. Time for study
     - a. Study as soon as possible after class.
     - b. Fill in notes or reorganize notes.
     - c. Do assignments as soon as possible after they have been given.

6. Reference materials
   - a. Use library frequently.
   - b. Look up new words in the dictionary or refer to glossary.
7. Taking a test
   - a. Read the question quickly but thoroughly. Read each word of the question and all choices.
   - b. Select the answer you believe is correct - usually your first thought is correct.
   - c. Restate each question in your own words.
   - d. Never erase or change an answer unless you are positive your first choice is wrong.

V. Personal Appearance of the Health Care Assistant (II-5)

A. Hygiene

1. Bathe daily.
2. Use deodorants.
3. Prevent bad breath by brushing teeth.
4. Females, change sanitary napkins frequently.
5. Fingernails
   - a. Short, trimmed
   - b. Neatly shaped
   - c. Cleaned
6. Hair
   - a. Neat and clean
   - b. Simple style
   - c. Short, not touching collar (Long hair must be pinned up or tied back so loose hairs do not contaminate.)
   - d. Keep hair out of face.

        e. Beards and mustaches should be neatly trimmed.

    7. Foot care - prevent odor/infection

  B. Clothing and accessories

    1. Uniforms of modest length or pantsuits, cleaned daily and mended.

    2. Change lingerie and underclothing daily.

    3. Undergarments should be worn.

    4. Jewelry is not considered a part of any uniform. (Check policy of facility.) **(II-6)**

        a. Wedding ring only

        b. Small, post earrings

        c. Watch with a second hand

    5. Stockings should be changed daily.

    6. Shoes should be comfortable and provide support.

        a. Clean and polish daily, if shoes are white.

        b. Wash shoestrings as needed.

        c. Color of shoes should be in accordance with facility policy.

    7. Make-up

        a. Use in moderation.

        b. Wear no strongly scented after-shave lotion or perfume as it tends to nauseate ill persons.

VI. Personal Health

  A. Eat a well-balanced diet. **(II-7)**

  B. Acquire adequate sleep and relaxation.

  C. Reduce stress (inner pressures) - have some type of leisure activity.

  D. Practice good posture.

  E. Never use alcohol or drugs before going on duty or while on duty.

F. Prevent disease.

   1. Handwashing - before and after care of clients, after going to bathroom, before eating

   2. Immunization - as required by facility

   3. Health maintenance program

G. Exercise

VII. Essential Traits and Attitudes for the Health Care Assistant (HOs 1-4) (II-8)

A. Personality - totality of an individual's behavioral and emotional tendencies

   1. Charm - how to please others

   2. Poise - even tempered, composed

   3. Dignity - pride, self-respect

   4. Attitudes - feelings about people, places, and things

      a. Positive

      b. Negative

   5. Habits - repetition of behavior; acquired

B. Conduct

   1. Confidentiality - do not disclose client's condition to friends or family

   2. Professional behavior

   3. Gossip

   4. Courtesy - consider others first

C. Dependability

   1. Report to work on time.

   2. Use facility procedure for absenteeism.

   3. Work habits

   4. Personal habits

VIII. Summary and Conclusion

A. Goals and objectives

B. Rules and regulations

C. Course requirements

D. Survival tips

E. Personal appearance of the health care assistant

F. Personal health

G. Essential traits and attitudes of the health care assistant

This lesson provided an overview of the course, its requirements, and how you can become a vital part of the health care delivery team and make a significant contribution to your life and society. The next lesson is on the health care team.

LESSON PLAN: 1

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

INTERACTION ITEMS:

1. What are the six objectives of this course?
2. How many rules and regulations from your student handbook can you describe?
3. What are the course requirements of this school?
4. What are seven study habit survival tips?
5. What should the personal appearance of a health care assistant be?
6. What three items of jewelry are usually acceptable when wearing a uniform?
7. What are seven personal health habits that the health care assistant should practice?
8. What are three essential traits of a health care assistant?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Role-play situations of appropriate behavior on the job.
2. Examine samples of assignment/activity sheets, procedure sheets, written and performance tests.
3. Outline plan to develop and/or improve study skills.
4. Invite a guest speaker (a cosmetologist) to offer a presentation on grooming.
5. Have class make a list of factors which make up their personalities.

ANSWERS TO EVALUATION ITEMS:

1. See page 5 - objectives of course for answers.
2. Answers will vary for schools.
3. Answers will vary for schools.
4. T
5. F
6. T
7. T

8. T
9. F
10. Daily
11. Collar
12. a) Wedding ring
    b) Small, post earrings
    c) Watch with second hand
13. Never
14. a
15. f
16. d
17. e
18. g
19. c
20. b

LESSON PLAN: 1

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I : INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

EVALUATION ITEMS:

1. List six objectives of the course.

   a.

   b.

   c.

   d.

   e.

   f.

2. List three rules and/or regulations from your student handbook.

   a.

   b.

   c.

3. List three course requirements as determined by instructor and/or school.

   a.

   b.

   c.

In the space provided, write "T" if the statement is true, or "F" if it is false.

____ 4. The study environment should be quiet.

____ 5. Soft radio music is okay to listen to while studying.

____ 6. A good study habit is to underline important words, sentences, and phrases.

____ 7. A good time to study is as soon as possible after class.

____ 8. When selecting an answer to a test question, usually your first thought is correct.

____ 9. Never restate the question in your own words, as this will confuse you.

Complete the following short answer questions.

10. The health care assistant should bathe ________________.

11. The health care assistant's hair should not touch the ________________________.

12. ______________ use alcohol or drugs before going on duty or while on duty.

13. What three pieces of jewelry are usually acceptable to be worn with the uniform.

    a.

    b.

    c.

Match the following traits of a health care assistant in Column II with their correct definitions in Column I.

		Column I		Column II
____	14.	Ability to please others	a.	Charm
____	15.	Even-tempered	b.	Confidential
____	16.	Uses facility's procedure when absent	c.	Courtesy
			d.	Dependability
____	17.	Pride, self-respect	e.	Dignity
____	18.	Feelings about people, places, and things	f.	Poise
____	19.	Considers others first	g.	Attitude
____	20.	Does not discuss client's condition with friends		

ESSENTIAL ATTITUDES FOR ESTABLISHING WORKING RELATIONSHIPS WITH CLIENTS

Politeness and Tactfulness

Politeness - a social courtesy

"Please"; "Thank you" - magic words
"May I help you?" with a smile
Allow others to pass - no pushing.
Be gentle in manner and tone.
Always address other employees and clients by surname or title (Mr., Mrs., Miss, Ms. or Dr.).

Tactfulness - skillful thoughtfulness in handling a situation

Think carefully before speaking to avoid offending others. Learn how to answer clients' questions to their satisfaction by referring to the appropriate resource person, etc. (such as, "Why don't we ask your doctor?").

Friendliness

Friendliness is warmth and good will between people and includes courtesy, confidence, and hospitality.

Patience

Patience is the ability to accept the client's behavior in a supportive manner and to convey the feeling that you are in sympathy with him/her, and are interested in his/her welfare.

Truthfulness

Truthfulness is best demonstrated by an earnest and sincere manner. All clients need to trust the people who care for them so that they can learn to rely on people.

Poise

To be composed in difficult situations requires thoughtful control and is not always easy.

Confidence in Ourselves and Others

When we have faith and assurance in ourselves, it tends to inspire the same in others.

Receptiveness

To listen to another person's interests politely, unselfishly, and tactfully is a compliment to that person. Listening can create a pleasant bond between two people.

PROMOTING POSITIVE HUMAN RELATIONS

1. **SPEAK TO PEOPLE.** There is nothing as nice as a cheerful word of greeting.
2. **SMILE AT PEOPLE.** It takes 72 muscles to frown, only 14 to smile.
3. **CALL PEOPLE BY NAME.** The sweetest music to anyone's ears is the sound of his/her own name.
4. **BE FRIENDLY AND HELPFUL.** If you would have friends, be friendly.
5. **BE CORDIAL.** Speak and act as if everything you do is a genuine pleasure.
6. **BE SINCERELY INTERESTED IN PEOPLE.** You can like almost anyone if you try.
7. **BE GENEROUS WITH PRAISE.** Practice caution with criticism.
8. **BE CONSIDERATE OF THE FEELINGS OF OTHERS.** It will be appreciated.
9. **BE THOUGHTFUL OF THE OPINIONS OF OTHERS.** There are usually three sides to a controversy: yours, the other person's, and the right one.
10. **BE ALERT TO GIVE SERVICE.** What counts most in life is what we do for others.

ADD TO THIS A GOOD SENSE OF HUMOR, A BIG DOSE OF PATIENCE, AND A DASH OF HUMILITY AND YOU WILL BE REWARDED MANY TIMES OVER.

POEM OF COMPASSION

(This poem was written by a woman who died in the geriatric ward of Ashludie Hospital near Dunde, England. It was found among her possessions and so impressed the staff that copies were made and distributed to every nurse in the hospital. It is addressed to the nurses who surrounded the woman in her last days. However, because it cries for recognition of common humanity, it could have been written to all of us.)

What do you see, nurse, what do you see?
Are you thinking when you look at me -
A crabbed old woman, not very wise,
Uncertain of habit with far away eyes,
Who dribbles her food and makes no reply
When you say in a loud voice - "I do wish you'd try."
Who seems not to notice the things that you do
And forever is losing a stocking or shoes,
Who resisting or not, lets you do as you will
With bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
Then open your eyes nurse, you're not looking at me.

I'll tell you who I am as I sit here so still.
As I move at your bidding, eat at your will,
I'm a small child of ten with a father and mother,
Brothers and sisters who love one another;
A young girl of sixteen with wings on her feet,
Dreaming that soon a love she'll meet;
A bride at twenty, my heart gives a leap,
Remembering the vows that I promised to keep;
At twenty-five now I have young of my own
Who need me to build a secure, happy home.

A woman of thirty, my young now grow fast,
Bound together with ties that should last.
At forty, my young sons have grown up and gone,
But my man's beside me to see that I don't mourn.
At fifty once more babies play round my knee -
Again we know children, my loved one and me.
Dark days are upon me, my husband is dead,
I look at the future, I shudder with dread.
For my young are all rearing young of their own,
And I think of the years and the love that I've known.

I'm an old woman now and nature is cruel.
'Tis her jest to make old age look like a fool.
The body it crumbles, grace and vigor depart.
There is a stone where I once had a heart.
But inside this old carcass a young girl still dwells,

And now again my bittered heart swells.
I remember the joys, I remember the pain
And I'm loving and living life over again.
I think of the years, all too few, gone too fast,
And accept the stark fact that nothing can last.
So open your eyes, nurse, open and see
Not a crabbed old woman.
Look closer - SEE ME!

GROOMING

Keeping Your Hair Clean and Neatly Groomed

Your hair must be clean and neat if you want to make a good impression.

1. At work, you need a haircut that won't attract negative attention or get in your way. Don't choose a style that covers your eyes.
    a. Get advice from a beautician or barber on the best cut for you.
    b. Choose a haircut that fits your lifestyle. If you don't like to spend time on your hair, you want a style that only needs to be washed and combed out.
2. Wash your hair at least two to three times a week.
    a. If you have oily hair, or if you work in a dirty place, you will need to wash your hair more often.
    b. You must use shampoo or soap. You may want to use other hair products too (hair conditioner, hair spray) if you think they make your hair look better.
3. Comb your hair often. Combing keeps your hair healthy, gets rid of tangles, and shapes your hair after you shower or bathe.
    a. Only comb your hair in a bedroom or bathroom. Don't comb it in a public place (a lunchroom or classroom).
4. Before you grow a beard or mustache, find out if your company has a policy on facial hair. See if anyone else at work has a beard or mustache. If you decide to grow a beard or mustache, it must be even and well-groomed.
5. You must shave, even if you choose to wear facial hair.
    a. Don't use a razor or blade that scrapes or chafes your skin. (Dull blades can scrape you.)
    b. Don't shave so often or so closely that you scrape or chafe your skin.

Maintaining a Clean and Well-Groomed Body

To make a good impression on the job, your body must be clean, well-groomed and free of strong or offensive odors.

1. Take a bath or shower every day. Make sure you use soap so you remove excess oils from your skin.
2. Use a deodorant or antiperspirant every day. A deodorant masks the smell of sweat. An antiperspirant tries to stop sweat from forming as well as masking its odor.

Deodorant may be enough for you. But if your clothes often get wet with sweat, you need an antiperspirant.

3. Keep your hands and feet clean.
    a. Wash your toes and the bottoms of your feet each day. Since feet perspire and are covered by shoes and socks (or hose), the feet get infected easily.
    b. Wear clean socks or hose each day and a different pair of shoes every other day.
    c. Keep your fingernails clean and neat.
    d. Keep your fingernails about fingertip length. Fingernails that are too long can get in the way, and nails that are too short can get infected.
    e. Wash your hands often during the day. Dirty hands pass germs.
4. Keep your mouth clean and in good repair.
    a. Brush your teeth at least twice a day. Gently scrub all surfaces in your mouth (including your tongue) with a soft-bristled toothbrush.
    b. Use dental floss to reach places a toothbrush cannot.
    c. Using mouthwash is O.K., but it cannot replace brushing.
    d. Visit the dentist at least once or twice a year. The dentist (or his staff) cleans your teeth and checks your mouth for damage or disease.

Using Cosmetics and Toiletries Properly

1. To learn what is appropriate, find out what others are using at work.

    In general, it is better to wear too little makeup than too much. If you don't know how to use makeup, get good advice. You can get help from books, fashion magazines or cosmetic counters in stores.
2. Be careful when using perfume, cologne, or after-shave.
    a. Don't wear a scent that is too strong. A scent should not send people running for cover.
    b. Don't buy perfumes or colognes you cannot afford. There are many good products sold that don't cost too much.

LESSON PLAN: 2

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I : INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

SCOPE OF UNIT:

This unit covers an overview of course objectives and requirements, effective study habits and test-taking skills, the types of health facilities, the members of the health care team and their functions, the role of the health care assistant relative to the health care team, and ethical and legal responsibilities.

INFORMATION TOPIC: I-2 OR DEMONSTRATION:

HEALTH CARE TEAM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Match selected health care team members with their major responsibilities in a long-term care facility.
3. Describe the lines of authority the health care assistant should follow.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Health Care Team - Acute Care Facility
2. HO 2: The Health Care Team - Long-Term Care Facility
3. HO 3: Omnibus Budget Reconciliation Act (OBRA)
4. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Working Together, video (TF #155), 18 min.
    b. Building Bridges: Ways to Improve the Quality of Long Term Nursing Care, video (TF #179), 20 min.
    c. Seven Days a Week, video (TF #81), 30 min.
5. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 2 (Student Reference page 15) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 2.

Medication Technician. Revised ed. University of Missouri-Columbia: Instructional Materials Laboratory, 1986.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 1.

Hegner, Barbara R; Ester Caldwell. Nursing Assistant: A Nursing Process Approach, 6th ed. Albany, NY: Delmar Publishers, 1992.

INTRODUCTION:

The term "health care team" is another way of describing the process by which people join together to diagnose, plan for, give care to, and rehabilitate those individuals with illnesses, injuries, or infirmities of old age who require health care. The concept of the health care team is based on the fact that it takes more than one or several individuals to provide effective care. In this lesson, you will learn about the individuals on the health care team and their specific responsibilities.

LESSON PLAN: 2

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

OUTLINE:

I. Terms and Definitions (II-1)

  A. Activities of daily living - any activity that is performed in one's life on a daily basis

  B. Social services designee - social services representative who is appointed by the resident in writing to take certain responsibilities and receive reports related to a resident's personal possessions and property

  C. Diagnosis - determining what kind of disease or medical condition a person has; the health care assistant can find out by looking in the chart; the doctor determines the problem based on tests, observations, etc.

  D. Elimination - to rid the body of wastes, such as urine or stool

  E. Emotion - one's feelings

  F. Mobility - ability to move

  G. Physical - relating to the body and the functioning of the body

  H. Psychological - associated with the thought processes of the brain

  I. Reality orientation - techniques used to assist a person to become aware of the world in which he/she lives

  J. Rehabilitation - restoring of an ill or injured client so he/she would be able to help himself/herself

  K. Responsible party - a family member/friend of the client who has been designated in writing by the client to handle matters and receive reports related to the client's general condition

  L. Restorative - returning a client to health or consciousness

  M. Social - relating to human society, getting along with others

  N. Long-term care facility - facility designed for care of clients for an extended period of time

O. Acute care facility - hospitals and clinics for immediate, short-term care

P. Health care facility - any facility designed for individuals requiring health care

Q. Home health agency - agency that provides extended care in the home

R. Hospital - a facility which provides care for clients of all ages with varied health problems

S. Hospice - care of persons during a terminal illness; either in the home or a health care facility

T. Residential care facility - a facility that provides twenty-four hour care to three or more non-related clients; may provide board, personal care, supervision of health care, and distribution of medications

U. Resident - this term is usually used when referring to individuals receiving health care in a long-term care facility

V. Patient - this terms is usually used when referring to individuals receiving health care in an acute care facility

W. Client - someone who pays a professional for services; can be a patient or resident

II. Health Care Team Members (HOs 1 & 2) **(II-2)**

A. Client and his/her family have particular needs which must be identified by team members.

B. Physician

1. Makes a diagnosis

2. Gives orders for medication and treatment

3. Guides plan of care

C. Administrator - responsible for all aspects of operation of the long-term care facility including delivery of proper client care

D. Nursing staff

1. Registered nurse (RN)

a. Length of training can be a two-, three- or four-year program.

b. Must pass a licensure examination administered by the State Board of Nursing upon completion of educational program

c. Duties

1) Plans, assigns, and evaluates nursing care

2) Responsible for all team members working together

3) Reviews quality of care

4) Gives medication

5) Starts IVs

6) Assists with client care (physical, psychological, and social)

7) Takes and records physician's telephone and verbal orders

8) Teaches nursing procedures

9) Administers tube feedings

2. Licensed practical nurse (LPN)

a. Length of training is one year.

b. Must pass a licensure examination administered by State Board of Nursing upon completion of education program

c. Duties

1) Plans, assigns, and evaluates nursing care

2) Gives medication

3) Starts IVs after successful completion of IV therapy course

4) Assists with client care (physical, psychological, and social)

5) Takes and records physician's telephone and verbal orders

6) Performs most treatments

7) Administers tube feedings

3. Certified medication technician (CMT)

a. Must have successfully completed the required course for Nurse Assistant in a Long-term Care Facility and/or meet other requirements before starting training for CMT

b. Must be a high school graduate or have a GED.

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c. Must pass final practicum examination before being certified

d. Duties

1) Prepares and administers selected medications

2) Transcribes physician's orders

3) Observes and reports effects of medications

4) Assists with client care

5) May administer insulin after successful completion of an Insulin Administration course

4. Certified nurse assistant (CNA)

a. Length of training is a minimum of 75 hours of classroom and 100 hours of on-the-job training and competency evaluation

b. Must pass final examination before qualified

c. Duties

1) Provides for and assists with activities of daily living

2) Provides bedside care which includes selected procedures under the supervision of the charge nurse

a) Feeding

b) Dressing

c) Bathing

d) Checking and recording vital signs

e) Weighing and measuring client

f) Bowel and bladder retraining

g) Reality orientation and other forms of communication with the client

h) Maintaining safe environment for clients and other staff

i) Transferring and positioning

j) Transporting client to activities planned by the activities director

        3) Makes accurate observations and reports to charge nurse

        4) Helps meet the emotional needs of the client

            a) Aware of client's emotional needs; alerts social services designee of problem through chain of command

            b) Is an effective communicator

E. Dietary employees

1. Dietitian (usually a consultant)

    a. Consults with dietary/food service supervisor

    b. Approves menus, evaluates, and counsels clients with nutritional problems

2. Dietary/food service supervisor

    a. Manages dietary department (orders supplies, foods, etc.)

    b. Interviews clients

    c. Supervises dietary employees

3. Dietary staff

    a. Prepares and serves food

    b. Washes dishes

    c. Keeps dietary area clean

F. General housekeeping and maintenance

1. Housekeeping employees

    a. Provide daily room care

    b. Responsible for cleaning all other areas of facility

2. Laundry employees

    a. Laundry of linen, bedding, and clothing

    b. Mending

3. Maintenance employees - general repair and grounds keeping

G. Activities director

   1. Conducts group and individualized activities so that each client of the facility is reached

   2. Supervises volunteers

   3. Schedules community sponsored activities in the facility

H. Physical therapist; occupational therapist; speech therapist (usually consultants)

   1. Plans and provides therapy essential to promote rehabilitation based on physician's orders

   2. Instructs staff in restorative nursing procedures

   3. Education - bachelor's or master's degree from a school accredited by the American Physical Therapy Association

I. Physical therapist assistant

   1. Assists the physical therapist in evaluating clients, setting up treatment programs, carrying out treatment programs and keeping notes on clients

   2. Education - graduate of a two-year associate degree program accredited by the American Physical Therapy Association

J. Occupational therapist

   1. Restore, maintain, or improve daily living skills such as eating, grooming, hygiene, toileting, and dressing

   2. Education - bachelor's degree from a school accredited by the American Therapy Association

K. Social services (designee)

   1. Screens clients prior to admission to a facility to determine if the facility can meet the client's needs

   2. During residency

      a. Assists with admission process - reviews rights and responsibilities of client and facility

      b. Counseling

         1) Has daily contact with client to determine if social and emotional needs are being met

2) If qualified, provides individual or family counseling--otherwise refers individual to qualified professional for assistance

c. Personal services

1) Financial resources - assists with insurance forms, pensions, social security, etc.

2) Secures aids to daily living (wheelchairs, canes, etc.)

3) Makes arrangements for outside services to meet client's needs

3. Discharge planning

a. Referrals (home health, another long-term health care facility, hospital)

b. Follow-up

L. Professional services

1. X-ray

2. Nuclear medicine

3. Research

4. Laboratories

M. Fiscal services

1. Admitting clerk

2. Accounting - business office

N. Administrative services

1. Personnel or human resources

2. Public relations

3. Purchasing

III. Chain of Command - Line of Authority **(II-3)**

A. If the health care assistant observes or suspects a problem, he/she should direct this concern to the next responsible person (immediate supervisor) and then follow each successively higher level along the chain of command until the problem is resolved.

B. Charge nurse (RN or LPN) is next in command.

C. Director of nursing is next.

D. Administrator is the health care team member with the most responsibility and ultimate authority.

IV. Summary and Conclusion

A. Terms and definitions

B. Health care team members

C. Chain of command - line of authority

The most important member of the health care team is the client and his/her family. All team members must join together to identify and meet each client's needs. They must communicate well with one another to give the best care possible. As a health care assistant, you must be aware of the lines of authority you are required to follow when a problem arises. The next lesson is on ethical and legal responsibilities.

LESSON PLAN: 2

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

INTERACTION ITEMS:

1. What is the definition of each of the terms: diagnosis, mobility, elimination, reality orientation, rehabilitation, restorative, designee, physical, psychological, social, emotion, responsible part, and activities of daily living?

2. What are the major responsibilities of the following health care team members: physician, dietary staff, RN, LPN, administrator, social service designee, health care assistant, activities director, physical therapist, and occupational therapist?

3. What chain of command or line of authority should health care assistants follow when reporting a potential problem?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide class into two groups. Assign titles of health care team members to each group. Have students prepare clues that will identify who the team member is. The other team then guesses who the member is based on the clues.

2. Have students role-play different levels of authority.

   a. Remind a staff member to do his/her job.

   b. Reprimand someone for consistently being late.

   c. Deal with a staff member who has not followed the chain of command while trying to solve a problem.

3. Review the facility's job description for health care assistants.

4. Show videos.

ANSWERS TO EVALUATION ITEMS:

1. f
2. j
3. i
4. k
5. h
6. l

7. a
8. e
9. g
10. d
11. b
12. c
13. b
14. d
15. b
16. e
17. a
18. d
19. g
20. c
21. f

22. The student should indicate in his/her response that the person to report the incident to would be the director of nursing. If the director of nursing is not available, the next person to inform would be the administrator.

LESSON PLAN: 2

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

EVALUATION ITEMS:

Match the following terms in Column I with the correct definitions in Column II.

Column I

___ 1. Diagnosis

___ 2. Mobility

___ 3. Elimination

___ 4. Reality orientation

___ 5. Rehabilitation

___ 6. Restorative

___ 7. Physical

___ 8. Psychological

___ 9. Social

___ 10. Emotion

___ 11. Responsible party

___ 12. Activities of daily living

Column II

a. Relating to the body and the functioning of the body

b. A family member/friend of the client who has been designated in writing by the client to handle matters and receive reports related to the client's general condition

c. Any activity that is performed in one's life on a daily basis

d. One's feelings

e. Associated with the thought processes of the brain

f. Finding out what kind of disease or medical condition a person has

g. Relating to a human society, getting along with others

h. Restoring of an ill or injured client so he/she would be able to help himself/herself

i. To rid the body of wastes, such as urine or stool

j. Ability to move

k. Techniques used to assist a person to become aware of the world in which he/she lives

l. Returning a client to health or consciousness

13. Which one of the following best describes the responsibility of the health care assistant? (Circle the letter of the best answer.)

a. Plans and assigns nursing care
b. Provides client bedside care under the supervision of a nurse
c. Assumes responsibility for all team members
d. Administers medications

14. A CMT has asked you to give some of her morning medications on several occasions. Who would you talk to about this? (Circle the letter of the best answer.)

a. Another health care assistant
b. The administrator
c. The physician
d. The charge nurse

Match the following health care team members in Column I with one responsibility in Column II associated with their job titles.

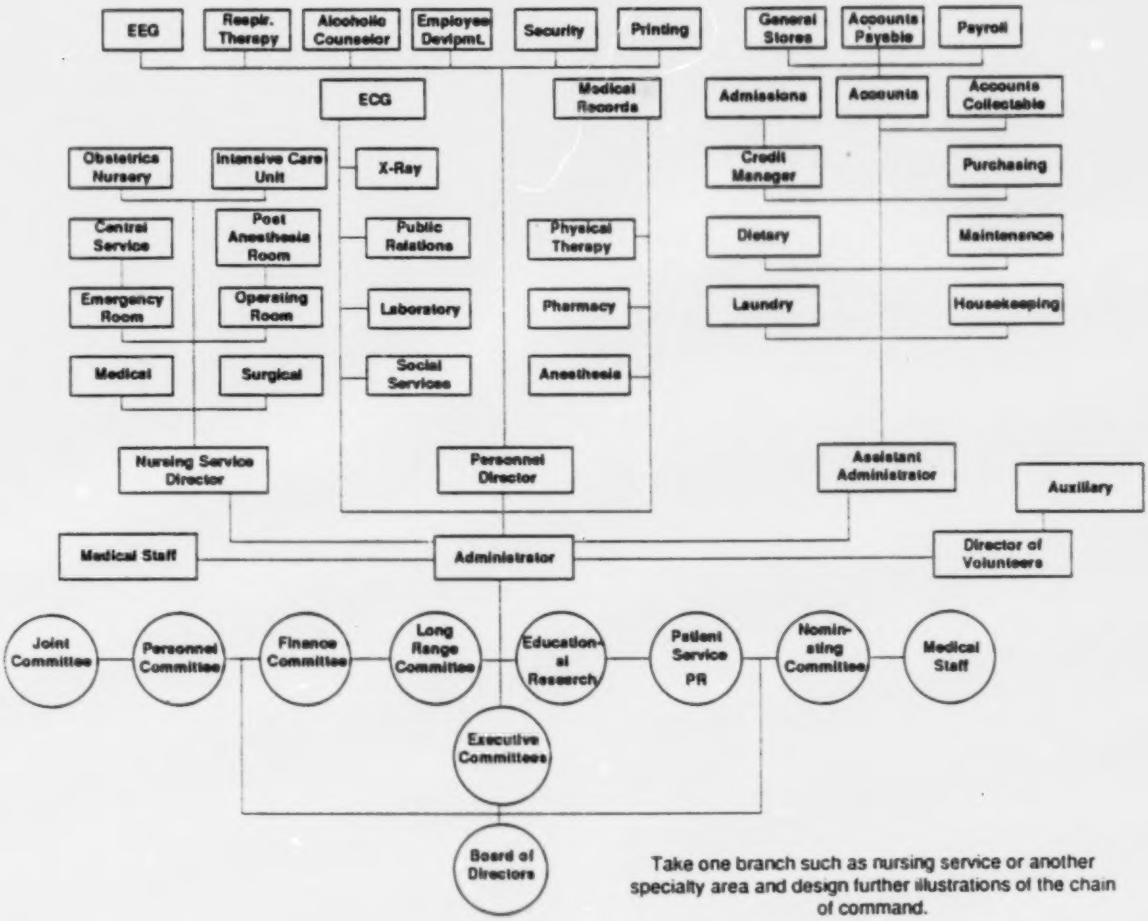
	Column I		**Column II**
___ 15.	Physician	a.	Plans, assigns, and evaluates nursing care
___ 16.	Dietary staff	b.	Writes orders for medications and treatments
___ 17.	Nurse (RN/LPN)	c.	Provides bedside care
___ 18.	Administrator	d.	In charge of the facility
___ 19.	Social service designee	e.	Prepares and serves food
		f.	Plans social events for the facility
___ 20.	Nurse assistant		
___ 21.	Activities director	g.	Helps client with admission, discharge, and personal affairs

22. You find the charge nurse smoking in one of the client's rooms. Who will you report this to? If that person is not available, who would be the next person to inform of the problem?

HO 1

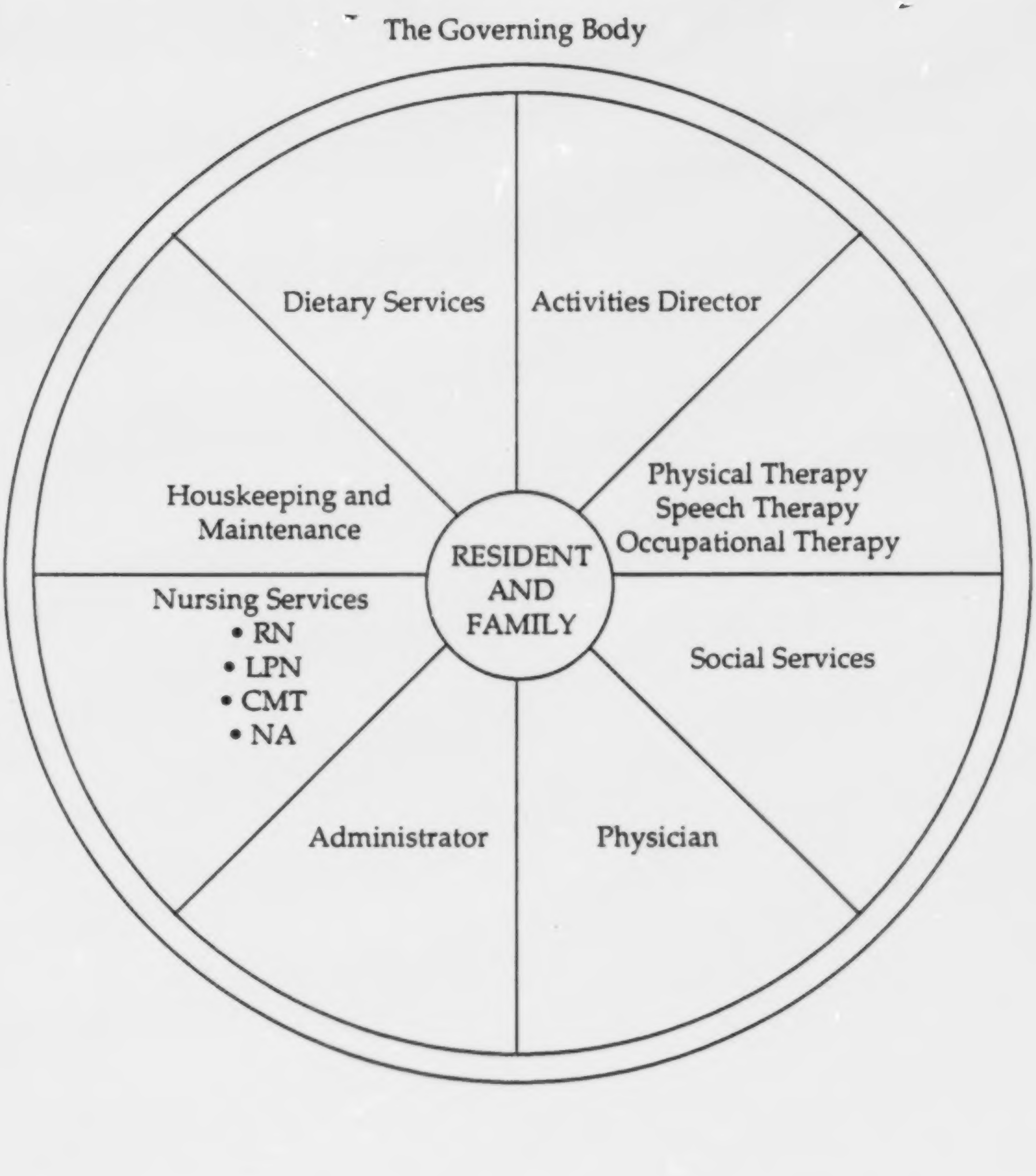
THE HEALTH CARE TEAM - ACUTE CARE FACILITY

Organizational Chart


EEG
Respir. Therapy
Alcoholic Counselor
Employee Devlpmt.
Security
Printing
General Stores
Accounts Payable
Payroll
ECG
Medical Records
Admissions
Accounts
Accounts Collectable
Obstetrics Nursery
Intensive Care Unit
X-Ray
Credit Manager
Purchasing
Central Service
Post Anesthesia Room
Public Relations
Physical Therapy
Dietary
Maintenance
Emergency Room
Operating Room
Laboratory
Pharmacy
Laundry
Housekeeping
Medical
Surgical
Social Services
Anesthesia
Nursing Service Director
Personnel Director
Assistant Administrator
Auxiliary
Medical Staff
Administrator
Director of Volunteers
Joint Committee
Personnel Committee
Finance Committee
Long Range Committee
Educational Research
Patient Service PR
Nominating Committee
Medical Staff
Executive Committees
Board of Directors

Take one branch such as nursing service or another specialty area and design further illustrations of the chain of command.

THE HEALTH CARE TEAM - LONG-TERM CARE FACILITY


The Governing Body
Dietary Services
Activities Director
Houskeeping and Maintenance
Physical Therapy
Speech Therapy
Occupational Therapy
RESIDENT AND FAMILY
Nursing Services
• RN
• LPN
• CMT
• NA
Social Services
Administrator
Physician

OMNIBUS BUDGET RECONCILIATION ACT (OBRA)

Federal regulations require that all states identify the basic education, level of competencies required for certification, and the duties and responsibilities of nursing assistants in long-term care facilities.

This law is called the Omnibus Budget Reconciliation Act (OBRA).

OBRA consists of regulations from the Department of Health and Human Services Care Financing Administration. The regulations establish, on the national level, the minimum requirements for nurse aide training and competency programs.

In 1987 a federal law was passed that regulates the education and certification of nursing assistants. This federal law became effective October 1, 1990. The following are required by the law.

A. Nurse assistants must complete a competency evaluation or a state approved course.

B. Nurse assistants must complete a minimum of 75 hours of theory and practice. (NOTE: Missouri requires 75 hours of theory and 100 hours of clinical practice.)

C. All nurse assistants working prior to 1989, must have completed a competency evaluation program by October 1, 1990.

D. Nurse assistant students may take the certification exam three (3) times. If they do not successfully pass the exam the third time, the entire course must be repeated.

E. A nurse assistant who has not worked for 24 months must complete a new training and competency program.

F. Continuing education is required. The number of hours varies with individual states.

G. The curriculum must include

1. Resident rights
2. Safety and emergency care
3. Personal care skills
4. Basic nursing skills
5. Basic restorative services
6. Mental health and social service needs

A nurse assistant must know the regulations and any legislation of the state in which they are employed. Remember, these are minimum federal requirements. A state may require more theory and clinical hours than is required by OBRA.

LESSON PLAN: 3

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

SCOPE OF UNIT:

This unit covers an overview of course objectives and requirements, effective study habits and test-taking skills, the types of health facilities, the members of the health care team and their functions, the role of the health care assistant relative to the health care team, and ethical and legal responsibilities.

INFORMATION TOPIC: I-3 OR DEMONSTRATION:

ETHICAL AND LEGAL RESPONSIBILITIES

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify techniques of proper documentation.
3. List six resident's rights.
4. Identify who should be notified if abuse, neglect, or exploitation is suspected.
5. List five areas of information needed when reporting an abuse, neglect, or exploitation case.
6. Explain the term grievance.
7. Describe the legal responsibilities of a health care assistant.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Resident's Rights - State of Missouri
2. HO 2: Resident's Rights - Federal
3. HO 3: Patient Self-Determination Act
4. HO 4: Abuse and Neglect Reporting

5. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Client Rights, 16mm film (TF #6D), 18 min.
    b. The Last Right, video (TF #75), 28 min.
    c. Criminal Justice Investigation, video (TF #54), 40 min.
    d. Ethics Committees: Allies in Long-Term Care, video (TF #187), 33 min.
    e. Pointers on Recording and Preparing for Court, video (TF #53), 90 min.
    f. The Detour, video (TF #11), 16 min.
    g. Elvira's Plight, video (TF #15), 10 min.
    h. Ethics and Gerontological Nurse Research, video (TF #58), 90 min.
    i. Elder Abuse: Five Case Studies, video (TF #186), 43 min.
    j. Elderly Abuse and Neglect in the Family/The Hidden Sorrow: An Overview, video (TF #71A), 24 min.
    k. Elderly Abuse and Neglect in the Family/in Pursuit of a Life without Violence, video (TF #71B), 26 min.

6. Audiovisuals available from the Missouri Vocational Resource Center
    a. Well Shut My Mouth (Confidentiality), video #4, 12 min.
    b. Residents Rights: The Art of Caring, video #18, 20 min.

7. Projector

8. Television and VCR

9. Facility's Policy Manual - "Grievance Procedure" section

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 3 (Student Reference page 29) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 7.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 3.

Medication Technician. Revised edition. University of Missouri-Columbia: Instructional Materials Laboratory, 1986.

State of Missouri. Long-Term Care Facility Regulations and Licensure Law for Residential Care Facilities I and II, Intermediate Care Facilities, and Skilled Nursing Facilities. Department of Social Services, Division of Aging, 1991. (Current manual should be used.)

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 1, Section 3.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 1.

INTRODUCTION:

Terms, definitions, proper documentation, and legal responsibilities pertain to all clients in health care facilities.

As an employee in the health care occupations, it is important for you to be aware of your legal and ethical responsibilities to prevent any medical or legal problems from developing. When functioning as a health care assistant, you are responsible and accountable for your own actions. There is a possibility that you may be sued and taken to court by a client and/or his/her family if you do not perform your job in a safe and proper manner. Therefore, you must be aware of state laws, rules, and certain legal terms and what they mean.

Legal relates to the law and ethical relates to a set of moral principles and values. When you serve clients in any way or have access to their records, you are expected to maintain their confidence and trust. Any violation of the client's confidence may be defined as an illegal or immoral act.

There are certain laws which protect clients while in a health care facility. The client voluntarily signs an admission agreement giving his/her consent for treatment and care, but the client has the right to refuse treatment unless he/she has been determined legally incapacitated.

The problems of abuse, neglect, and exploitation were also addressed in the Omnibus Nursing Home Act of 1979 and Omnibus Reconciliation Act (OBRA) of 1987. Resident's rights pertain to individuals in long-term care. We will be discussing what these terms mean, as well as what to do if you believe a resident's rights are being violated in such a way.

LESSON PLAN: 3

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

OUTLINE:

I. Terms and Definitions **(II-1)**

- A. Abandonment - leaving client unattended

  Example: Leaving in the middle of a shift

- B. Abuse - the infliction of physical, sexual, or emotional injury or harm

  Example: Slapping a client

- C. Assault - threat or attempt to injure another in an unlawful manner

  Example: Telling a client, "If you don't be quiet, I'll tie your hands down."

- D. Battery - unlawful application of force to the person of another

  Example: Carrying out the above threat

- E. Conduct - one's actions in general; behavior

- F. Consent - permission granted voluntarily by a person in his/her (sound/clear) mind

- G. Ethical - relating to a set of moral principles and values

- H. Ethics - the discipline dealing with that which is good and bad and that which is moral duty and obligation

- I. Exploitation - illegal or improper use of a person's property or resources to the degree that substantial risk of harm exists

  Example: Not giving care without gifts or tips

- J. False imprisonment - unjustified detention of a person

  Example: Applying restraints to a client who is not mentally impaired and who does not have a legal guardian

- K.- Invasion of privacy - a civil wrong that unlawfully makes public knowledge of any private or personal information without the consent of the wronged person

Example: Discussing with a friend the care of a client which involves personal information, without the permission of the client

L. Legal - relating to the law

M. Libel - a false and malicious publication in writing about an individual or group to a third party

N. Malpractice - improper or negligent treatment of a client resulting in damage or injury

Example: Observing daily that a wound is becoming infected and not reporting it to the charge nurse

O. Morals - your own personal values

P. Neglect - failure of person(s) responsible for an individual to provide necessary services to maintain the physical and mental health of the individual, when such failure presents an imminent or probable danger to the individual

Q. Negligence - failure to perform in a reasonably prudent manner or by acceptable health care practices

Example: Leaving bedside rails down on a bed occupied by a confused client, which results in the client falling out of bed

R. Perpetrator - person who inflicts harm

S. Privileged communication - any personal or private information which is relevant to a client's care, given by the client to medical personnel

T. Slander - to make any oral defamatory false remark about another, spoken words that tend to damage the reputation of another

Example: Stating that a client is a "crazy old woman and out of control" to a friend of yours who knows the client

U. Value system - behavior related to a pattern of conduct or ideas that are accepted as worthwhile or meaningful

II. Techniques of Proper Documentation (II-2)

A. Remember--the chart is a legal document accepted in a court of law.

B. Be objective--chart only what happens, do not write your own opinions.

C. Use ball-point ink pen at all times since it is a permanent record.

D. Follow proper charting form; spell correctly.

III. Resident's Rights (HOs 1, 2, & 3) **(II-3)**

INSTRUCTOR NOTE: Discuss Handouts 1 and 2 in class, reviewing each of the rights listed. Discuss the Patient Self-Determination Act, Handout 3.

A. The client has rights just as you do.

B. Each facility should have a section in the policy and procedure manual that explains how each resident's rights are to be implemented and ensured.

IV. If you suspect abuse, neglect, or exploitation, notify Division of Aging through the hot line number (1-800-392-0210) (HO 4) **(II-4)**

A. Abuse, neglect, or exploitation may be perpetrated by:

1. Staff members - CNA, CMT, RN, LPN, dietary or maintenance personnel, etc.

2. Family members

3. Visitors

4. Other clients

B. Physical signs of abuse

1. Burns in unusual locations

2. Bruises on both upper arms

3. Bruises resembling an object

4. Bruises on trunk from repeated striking

5. Broken eyeglasses - lens or frames

6. Cuts/welts/black eye

7. Anything that appears suspicious should be reported

C. Behavioral signs of emotional abuse

1. Sudden change in behavior

2. Withdrawal

3. Lack of complaints

D. Physical signs of neglect

1. Unkempt appearance
2. Untrimmed nails
3. Signs of dehydration
4. Weight loss
5. Pressure ulcers

E. Exploitation - to protect the client, laws exist that prohibit the acceptance or solicitation of money or any item having monetary value from the client. This includes:

1. Staff of the facility
2. Volunteers at the facility
3. Other clients

F. Any person who knowingly abuses or neglects a client of a facility could be charged with a Class D felony. If convicted, the person could serve two to five years in a Missouri State Penitentiary or one year in county jail, be fined up to $5,000 for each offense, or be fined and serve the time.

G. The Division of Aging shall maintain a record of the names of any persons who have been determined to have knowingly abused or neglected a client while employed in any facility.

H. No licensed operator of a facility shall knowingly employ any person who has been determined to have knowingly abused or neglected a client whose name is listed in the records.

V. Information to Give Division of Aging (II-5)

A. Name and address of client

B. Name and address of the facility

C. Nature and extent of victim's condition or nature of abuse or neglect

D. Name of person making report or complaint (will be held confidential)

E. Name of alleged perpetrator (person who inflicted the harm) if known

VI. Grievance Procedure (II-6)

A. Grievance - a cause of distress which justifies complaint or resistance

B. May be filed by a client or employee

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C. Grievance procedure for each facility should be outlined in writing and appear in that facility's policy manual; please refer to it.

VII. Legal Responsibilities of a Health Care Assistant - The health care assistant can prevent legal and ethical problems from developing while caring for clients by remembering the following rules:

A. Remember, the client is your responsibility while you are in charge of his/her care. Do not abandon your job.

B. Be aware of the resident's rights and avoid violating them.

C. Prepare all paperwork correctly.

D. Know the lines of authority--do only those things which you have been trained and supervised to do.

E. Do not give personal information about a client over the telephone--refer all calls to the nurse.

F. Do not discuss with others not involved in the client's care (either in the facility or outside) a client's behavior, medical condition, or his/her personal matters (if calling the Division of Aging hot line 1-800-392-0210, you may discuss a client's behavior and medical condition).

VIII. Summary and Conclusion

A. Terms and definitions

B. Techniques of proper documentation

C. Resident's rights

D. Abuse, neglect, and exploitation reporting

E. Information to give division of aging

F. Grievance procedure

G. Legal responsibilities of a health care assistant

In this lesson, we have discussed ethical and legal terms and residents' rights. It is the health care assistant's responsibility to report any evidence of abuse, neglect, and exploitation. The next unit is on communication and observation skills.

LESSON PLAN: 3

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I: INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

INTERACTION ITEMS:

1. What is the definition of the following terms: conduct, battery, false imprisonment, slander, negligence, assault, libel, ethics, exploitation, abuse, and neglect?
2. What are four techniques of proper documentation?
3. How many resident's rights can you describe?
4. Who do you notify if you suspect abuse, neglect, or exploitation?
5. What five areas of information are needed when reporting an abuse, neglect, or exploitation case?
6. How is the term grievance defined?
7. What are the legal responsibilities of the health care assistant?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Role-play some situations that involve legal/ethical conduct:
    a. You have just witnessed a coworker slapping a client who is resisting her efforts to get him to bed.
    b. One of your clients in long-term care is making repeated attempts to go out-of-doors. In order to keep him safe while you give care to another, you tie him to a chair.
2. Role-play some situations that involve resident's rights:
    a. A visitor has just given a client a $20 bill. You know this confused person cannot manage it safely.
    b. A husband is visiting his wife who is a client. The door to the room is closed, and you need to deliver fresh water.
    c. You are a client who receives personal mail that has been opened.
3. Show slide and/or video presentations.

BEST COPY AVAILABLE

4. Describe and discuss the grievance procedures from the different facilities represented.

ANSWERS TO EVALUATION ITEMS:

1. b
2. g
3. h
4. e
5. c
6. a
7. f
8. d
9. b
10. c
11. a
12. b

13. The student may list any six of the rights contained in HOs 1 and 2 from this lesson.

14. c
15. d
16. b
17. b
18. b

19. a. Name and address of client
    b. Name and address of the facility
    c. Nature and extent of victim's condition or nature of abuse or neglect
    d. Name of person making report or complaint
    e. Name of alleged perpetrator

20. A grievance is a cause of distress which justifies complaint or resistance.

21. a

LESSON PLAN: 3

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT I : INTERPERSONAL RELATIONSHIPS AND THE HEALTH CARE TEAM

EVALUATION ITEMS:

Match the following terms in Column I with the correct definitions in Column II.

Column I		**Column II**
___ 1. Conduct	a.	Verbally threatening to hurt someone
___ 2. Battery	b.	One's actions in general
___ 3. False imprisonment	c.	Failure to perform in an acceptable manner
___ 4. Slander	d.	The discipline dealing with that which is good and bad
___ 5. Negligence	e.	Telling something false about someone
___ 6. Assault	f.	Writing defamatory matter about an individual
___ 7. Libel	g.	Unlawful application of force to the person of another
___ 8. Ethics	h.	Holding someone against his/her will

9. Which is a true statement concerning documentation on a client chart? (Circle the letter of the best answer.)

   a. White out errors made when charting.
   b. Use ball point ink pen at all times.
   c. Charting with a pencil is acceptable practice.
   d. The chart is not a legal document.

Match the following terms to correct definitions by writing the letter in the blank.

___ 10. Exploitation

___ 11. Abuse

___ 12. Neglect

a. The infliction of physical, sexual, or emotional injury or harm

b. Fail to adequately take care of a person, causing danger to him/her

c. Illegal or improper use of a person's property to the degree that substantial risk or harm exists

13. List six rights the resident has.

    a.

    b.

    c.

    d.

    e.

    f.

14. Which one of the following is an example of resident's rights? (Circle the letter of the best answer.)

    a. A nursing student can observe a procedure performed on the client without his/her permission.
    b. Clients and their visitors must visit in an area where you can hear and see them.
    c. Letters sent to the client must not be opened by the health care assistant without the client's permission.
    d. Clients must use the telephone in an area where the conversation can be overheard.

15. The right to participate in client and family groups means: (Circle the letter of the best answer.)

    a. The client's family can only meet with the client, not with families of other clients.
    b. The group may meet but not recommend changes in facility policy.
    c. The client has the right to participate in religious activity but must get to the activity without assistance from the facility.
    d. The group can discuss concerns and offer suggestions to improve the quality of life in the facility.

16. When a client has an item lost, stolen, or damaged the facility must investigate the situation and police assistance requested if necessary. This is an example of the resident's right to: (Circle the letter of the best answer.)

    a. Freedom from abuse.
    b. Care and security of personal possessions.
    c. Freedom from mistreatment.
    d. Privacy and confidentiality.

17. The right to not have body movement restricted is an example of freedom from: (Circle the letter of the best answer.)

    a. Security
    b. Restraints
    c. Participation
    d. Verbal abuse

18. If you suspect abuse, neglect, or exploitation of a client, you would notify: (Circle the letter of the best answer.)

    a. The State Board of Nursing
    b. The Division of Aging
    c. The attorney general's office
    d. The local prosecutor's office

19. List five areas of information needed when reporting an abuse, neglect, or exploitation case.

    a.

    b.

    c.

    d.

    e.

20. Define the term grievance.

21. The health care assistant can prevent legal and ethical problems from developing while caring for a client by: (Circle the letter of the best answer.)

    a. Not violating resident's rights.
    b. Doing everything you're told to do even if you have not been taught the task.
    c. Giving personal information concerning the client to family members over the phone.
    d. Discussing a client's behavior with a co-worker while traveling home on a bus.

RESIDENT'S RIGHTS - STATE OF MISSOURI

NOTE: I, II, and III refer to the type of deficiency in standards. See the state regulations for more information.

Requirements for all types of Licensed Long-term Care Facilities, 1991.

The resident has the:

1. Right to be fully informed of his/her rights and responsibilities as a resident and of all facility rules governing resident conduct and responsibilities. A copy of the resident's rights along with rules governing conduct and responsibilities must be provided all incoming and present residents in the facility. The facility must document that this information was given to the resident or his/her legal guardian. (III) Information regarding resident's rights and facility rules must be posted in a conspicuous location in the facility and copies be provided to anyone requesting this information. (III)

2. Right to be fully informed in writing of services available and the charges for those services if they are not covered in the daily room charge. The resident must be informed in writing of charges and of rate changes during his/her stay. The resident has the right to choose his/her own supplier for services not included in the daily rate. Information provided must include procedures to be followed by the facility in case of medical emergency, including transfer agreements and cost. (II, III)

3. Right to be fully informed by a physician of his/her health and medical condition, unless medically contraindicated, (I, II) and has the right to participate in planning his/her medical treatment. (II)

4. Right of selecting his/her own physician who will be responsible for the resident's total care. (II)

5. Right to be transferred or discharged only for medical reasons, or his/her health or welfare or that of other residents; or for nonpayment of stay. (II) If a resident is transferred or discharged for the welfare of other residents, the facility must have first informed the resident, family, or legal guardian of the rules and how the conduct represents a threat to the health or welfare of the other residents. (III) The resident, family, or legal guardian must be given ten (10) days notice of discharge or transfer except in an emergency situation. Room transfer within the facility is permitted if it does not result in any detriment to the resident's mental, physical, or emotional condition and should be explained as far ahead of time as possible. (II, III)

   A reasonable effort to arrange for services to assure continuity of care in meeting the resident's needs through other resources must be made if the resident is transferred or discharged. (II, III)

6. Right to exercise his/her rights as a resident and as a citizen, to voice grievances, and to recommend changes in policies and services to facility personnel or to outside representatives of his/her choice. A staff person shall be designated to receive complaints. The facility shall assist residents in exercising their right to vote. (II, III) The exercise of

resident's rights shall be free from restraint, interference, coercion, discrimination, or reprisal. (II, III)

7. Right to see copies of inspection and deficiencies and copies of plan(s) of correction and revised inspection reports. (II, III)

8. Right to be free of chemical and physical restraints except when authorized in writing by a physician for a specified period of time. (I, II) In an emergency, a physical restraint may be used to protect the resident from injury to himself/herself or others if authorized by the administrator, licensed nurse, or the operator. This action must be reported to the physician immediately and an order obtained which includes the length of time the restraint may be used, type of restraint, reason for restraint, and what course of action to take. This order must be signed by the physician within seven (7) days. (II, III)

9. Right to confidential treatment of any medical, personal, or financial records and may approve or refuse the release of records to anyone outside the facility. (II, III) Facility personnel shall not discuss aspects of the resident's record or care in front of persons not involved in the resident's care or in front of other residents.

10. Right to be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and care of his/her personal needs. (II, III)

11. Right not to be required to perform services for the facility that are not for therapeutic purposes in the plan of care. (II, III)

12. Right to communicate with persons of his/her choice. (II, III)

13. Right to meet alone with persons of his/her choice and in an area which assures privacy. (II, III)

14. Right to accessible use of telephones to make and receive calls and privacy when possible. (II, III)

15. Right to privacy of his/her mail. If a resident cannot open mail, a written consent by the resident or legal guardian must be obtained to have mail opened and read to the resident. (II, III)

16. Right to meet with and participate as well as not participate in activities of social, religious, and community groups at his/her discretion unless medically contraindicated. (II, III)

17. Right to keep and use personal clothing and possessions as space permits. There must be a record of all personal items which the resident brings with him/her upon admission or brought to him/her during his/her stay. These items are to be returned to the resident or responsible party upon discharge, transfer, or death. (II, III)

18. Right, if married, to privacy for visits by his/her spouse. If both parties are residents of the home, they will be permitted to share a room unless medically contraindicated. If the married couple's door is closed, personnel must knock and wait for an invitation to enter. (II, III) If no response is given, staff shall be permitted to enter the room.

19. Right for the option of purchasing or renting goods and services not included in the monthly per diem rate from a supplier of his/her choice, providing the quality of the goods and services meets the reasonable standards of the facility. Freedom to choose a pharmacy shall be permitted provided the facility's policy and procedures for packaging specifications are met. (II, III)

20. Right to not have their personal lives regulated or controlled beyond reasonable adherence to meal schedules and other written policies which may be necessary for the orderly management of the facility and the personal safety of the residents. (II)

21. The facility shall retain and make available for public inspection a list of names, addresses, and occupations of all individuals who have property interest in the facility. Also, the facility shall retain and make available for public inspection the statements of deficiencies, copies of plan(s) of correction, acceptance or rejection of the plan(s) and the revisit inspection report. (II, III) Any notice of non-compliance and inspection report shall be posted in a conspicuous location. (II, III)

22. A copy of the most current Division of Aging rules shall be kept in an easily accessible place for all persons to read. (II, III)

RESIDENT'S RIGHTS - FEDERAL

Residents have a right to dignity, self-determination, and communication with and access to persons and services inside and outside the facility. This facility shall protect and promote the rights of each resident which shall include the following rights:

1. RIGHT TO EXERCISE RIGHTS AS A RESIDENT of the facility AND AS A CITIZEN of the United States. The right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising these rights. If the resident is adjudged legally incompetent, the rights of the resident are exercised by the person appointed by law to act on the resident's behalf.

Example:
A resident of a nursing facility, unless he or she has a legal guardian, has all the rights that any other citizen has. For example, if Mary Brown wishes to vote in the annual elections for county officials, she may request an absentee ballot. If she is physically able to go out of the facility, she may go to the polls and vote.

Another example would be the event of theft of personal property from a resident in the nursing facility. The resident has the right to have a police investigation and file charges if he or she so desires.

THE RIGHT TO BE FREE OF INTERFERENCE, COERCION, DISCRIMINATION, OR REPRISAL FROM THE FACILITY IN EXERCISING THESE RIGHTS.

Example:
Mary Brown had a diamond ring in her room at the nursing facility. It was missing when she returned from lunch. Using the telephone in her room, she called the police. Later, the ring was found in another drawer in her room. Mrs. Smart, the administrator, threatens Mary Brown, saying, "If you ever call the police to this nursing home again, I'll have the phone removed from your room!" This is an example of interference, discrimination, and reprisal against a person exercising her rights as a citizen. Had Mrs. Smart been present before Mrs. Brown called the police and talked her out of calling the police by saying "If you call the police, it will cause a lot of trouble for you here!", that would be an example of coercion.

IF THE RESIDENT IS ADJUDGED LEGALLY INCOMPETENT, THE RIGHTS OF THE RESIDENT ARE EXERCISED BY THE PERSON APPOINTED BY LAW TO ACT ON THE RESIDENT'S BEHALF.

Example:
Jane Doe, age 79, has Alzheimer's Disease and is no longer able to make her own decisions. Her son, Paul Doe, lives in the community and was appointed to be guardian for his mother. He may make all pertinent decisions for his mother. Two years later, Paul Doe is transferred to a job 1,000 miles away. Because of his inability to be present, he asks the Public Administrator to accept appointment as his mother's guardian.

It will be found, however, that not all persons who are unable to make decisions have guardians appointed. For those persons, nursing staff need to consult with family, social services, physician, and administration to decide on a plan of care.

2. RIGHT TO BE INFORMED OF RULES AND REGULATIONS...To be informed orally and in writing of his or her rights and rules and regulations governing resident conduct and responsibilities during the stay in the facility.

   Example:
   When Bill is admitted to a nursing facility, the rights as well as rules, regulations, and responsibilities must be reviewed with Bill and/or his family. Because of the large amount of information being presented, Bill will need to have these rights reviewed with him during his stay also.

3. RIGHT TO DOCUMENTATION...has the right to orally or in writing request access to all records pertaining to himself/herself. The records must be furnished within 24 hours of the request. After receipt of the records, the resident has the right to purchase at a community standard cost photocopies of the records. The facility has two days to furnish the photocopies.

4. RIGHT TO MEDICAL CONDITION INFORMATION...The right to be fully informed in understandable language of total health status, including, but not limited to, his or her medical condition.

   Example:
   Mary Brown asks Pam Perfect, nurse assistant, to tell her what is "really wrong with me." Pam knows that she cannot tell Mrs. Brown about her medical condition. She goes to the charge nurse and tells her Mary Brown wants to know more about her medical condition. The charge nurse reviews Mrs. Brown's medical record and goes to Mary Brown's room to discuss her condition with her. THIS IS THE CORRECT WAY TO HANDLE THIS SITUATION AND PROTECT THE RESIDENT'S RIGHT TO BE INFORMED ABOUT HER MEDICAL CONDITION.

5. RIGHT TO REFUSE TREATMENT AND PARTICIPATION IN RESEARCH...has the right to refuse treatment in accordance with state laws and to refuse to participate in experimental research.

   Example:
   A new drug for the treatment of high blood pressure is available on a limited basis for test studies. Several residents of the nursing facility are asked to participate in a study of the effectiveness of the new drug. John Doe is one of the residents asked, but he refuses. THIS IS HIS RIGHT.

6. RIGHT TO KNOW SERVICES AVAILABLE...has the right to be informed before, or at the time of admission, and periodically during his or her stay, of services available and of charges for those services, including charges for services not covered under Medicare or by the facility's per diem rate.

Example:
Upon admission, Melvin Brown and/or his family must be made aware of the current charges and of all the services that are available. For example, if a telephone may be installed in the room for an extra charge, Melvin should be told. If permanents are given at the beauty shop, the cost should be made known. Other services that Melvin might wish to obtain include: therapy services, items that may be ordered from an outside businesses (food, cosmetics, toiletries, etc.).

7. RIGHTS TO A WRITTEN DESCRIPTION OF LEGAL RIGHTS WHICH INCLUDE:

   A. A description of the manner of protecting personal funds.

   B. A description of the requirements and procedures for establishing eligibility for Medicaid.

   C. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

   D. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.

8. THE RIGHT TO BE INFORMED OF THE NAME, SPECIALTY, AND WAY OF CONTACTING THE PHYSICIAN RESPONSIBLE FOR HIS OR HER CARE.

9. THE RIGHT TO ORAL AND WRITTEN INFORMATION ABOUT HOW TO APPLY FOR AND USE MEDICARE AND MEDICAID BENEFITS, AND HOW TO RECEIVE REFUNDS FOR PREVIOUS PAYMENTS COVERED BY SUCH BENEFITS.

10. RIGHTS PERTAINING TO NOTIFICATION OF CHANGE

    A. A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:

       1) An accident involving the resident and has the potential for requiring physician intervention.

       2) A significant change or deterioration in the resident's health, mental, or psychosocial status in either life-threatening conditions or clinical complications.

       Example:
       Mary Brown has generally been able to manage dressing herself daily and going to the bathroom alone. One morning before breakfast, she is found in her room taking all the contents out of her drawers and is rambling, "I know my coffee pot is in here somewhere." This indicates a serious change in mental condition and notification must be made.

3) A need to discontinue an existing form of treatment or to commence a new form of treatment.

Example:
Changes in medication, especially a new medication, would be an example of significant change of treatment. For example, John Doe is a resident. On monthly blood pressure check, the reading is found to be too high. After re-checking the reading, the physician orders a new blood pressure medication. The situation must be explained to the resident and family.

4) A decision to transfer the resident from the facility. Any time it becomes necessary to transfer a resident to a hospital or other health care facility, the notification must be made.

B. The facility must also promptly notify the resident and if known, the resident's legal representative or interested family member when there is:

1) A change in roommate

Example:
Two roommates, Jane Doe and Mary Badmood, have an argument. Both are upset and Mary insists on moving to another room immediately. Another room is available and Mary moves within the hour. Notification must be made.

2) A change in resident's rights under federal or state laws or regulations.

C. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

11. THE RIGHT TO MANAGE HIS/HER FINANCIAL AFFAIRS, AND THE FACILITY MAY NOT REQUIRE THE RESIDENT TO DEPOSIT HIS/HER PERSONAL FUNDS WITH THE FACILITY.

A. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for funds deposited with the facility.

B. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account that is separate from any of the facility's operating accounts, and credit all interest earned on the resident's funds to that account.

C. A resident's funds that do not exceed $50 may be kept in a non-interest bearing account, or petty cash fund.

D. The facility must establish and maintain a system that assures a full and complete and separate accounting of each resident's personal funds.

1) The system must not commingle the resident's funds with the facility funds or with the funds of any person other than another resident.

2) Financial records must be made available through quarterly statements by request of the resident or legal representative.

E. The facility must notify each resident that receives Medicaid benefits when:

1) The account reaches $200.

2) The amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the Supplementary Security Income (SSI) resource limit for one person.

F. Upon death of a resident with a personal fund, the facility must convey within 30 days the resident's funds and an accounting of these funds to the individual or probate jurisdiction administering the resident's estate.

G. The facility must purchase a security bond, or otherwise provide assurance satisfactory to the head of federal health care finance administration, to assure the security of all personal funds of the resident deposited with the facility.

H. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

12. RIGHT OF CHOICE OF PHYSICIAN AND PARTICIPATION IN PLAN OF CARE...has the right to choose a personal physician and be fully informed in advance of care and treatment which may affect the resident's well-being; and, unless adjudged incompetent or incapacitated by a court of law, participate in the plan of care and treatment or changes in care or treatment.

Example:
A facility may not urge that a resident choose a physician of the facility's choosing. If the resident has a preference of physician that will provide services at the facility, that physician must be asked to take the resident's case.

13. RIGHT TO PRIVACY AND CONFIDENTIALITY of his or her personal and clinical records which includes accommodations, medical treatment, written and telephone communications, personal care, visits and meetings with family and resident groups; however, this shall not require the facility to provide a private room. The resident may approve or refuse the release of personal clinical records to an individual outside the facility. This right does not apply to situations when the resident is transferred to another health care facility or the record release is required by law or third party contract. (e.g., Medicare, Medicaid, or insurance)

Example:
Jane Doe must be bathed by facility personnel. It must be assured that her privacy will be protected by having the curtains, both the window and cubicle, drawn; and the door will be closed. It will also be necessary to cover Mrs. Doe with a bath blanket and expose only the part of the body that is being bathed.

14. RIGHT TO VOICE GRIEVANCE...In respect to treatment or care that is given or failed to be given, the resident has the right to voice a grievance without discrimination or reprisal for voicing grievances and to expect prompt efforts by the facility to resolve the grievance. This includes grievances pertaining to the behavior of other residents.

    Example:
    Residents are upset by another resident yelling several hours each day. One resident, Mary Smith, comes to the administrator to complain. Some action will be required.

15. RIGHT TO EXAMINE SURVEY RESULTS...the most recent inspection of the facility conducted by federal or state surveyors and the facility's plan of correction must be made available if resident wishes to examine them.

16. RIGHT TO CONTACT WITH PATIENT ADVOCACY SERVICES...the resident has the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies.

    Example:
    A resident may have private visits from anyone he or she wishes to see. This may include ombudsman representative, attorneys, etc.

17. RIGHT TO REFUSE WORK...the resident cannot be required to perform services for the facility. The resident can perform services for the facility if he or she chooses when:

    A. There is documented need or desire for work in the plan of care.

    B. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

    C. Compensation for paid services is at or above prevailing rates.

    D. The resident agrees to the work plan.

18. RIGHT OF PRIVACY OF HIS/HER MAIL...the resident has the right to send and promptly receive mail unopened and has access to stationery, postage, and writing implements at the resident's own expense.

    Example:
    John Doe, a resident in Good Rock Home, gets upset when he receives mail from his ex-wife. Even though the staff thinks it might be best if John Doe didn't get this mail, it IS HIS RIGHT TO DO SO.

19. RIGHT OF ACCESS AND VISITATION RIGHTS...the resident has the right to have immediate access to any representative of the Secretary of the Department of Health and Human Resources, any representative of the State of Missouri, the individual's physician, the long-term care ombudsman, and the agency responsible for the protection and advocacy system for developmentally ill individuals and for the mentally ill. The resident has the right for families and others to visit freely. The resident, however, may refuse to see any of the above if he/she desires. The ombudsman may also examine the clinical

record, with the permission of the resident or the resident's legal representative, and consistent with the state law.

20. RIGHT TO TELEPHONE...the resident has the right to regular access to private use of a telephone where calls can be made without being overheard.

    Example:
    Residents may use a telephone regularly. They may be held responsible for paying long distance service charges.

21. RIGHT TO HAVE PERSONAL PROPERTY...the resident has the right to retain and use personal possessions including some furnishings and appropriate clothing as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

    Example:
    When John Doe came to Good Rock Nursing Home, he had been living in a four-room house. A pick-up truck and a van delivered his possessions to the nursing home. John Doe has the right to keep his personal possessions, only to the extent that it does not infringe upon the space of others. Obviously, John Doe will have to send some of his possessions to another location. John should never be required to wear clothing other than his own.

22. RIGHT TO MARITAL PRIVACY...the resident has the right to share his/her room with the spouse when married residents live in the same facility and both spouses consent to the arrangement.

    Example:
    Mr. and Mrs. M. are residents of the same facility. They wish to be in the same room. They have the right to do this. They also have the right to privacy when they wish.

23. RIGHT TO SELF-ADMINISTER DRUGS...the resident has the right to self-administer drugs unless the inter-disciplinary health care team determines that the practice is unsafe for this resident.

24. RIGHTS PERTAINING TO TRANSFER AND DISCHARGE...the resident must be permitted to remain in the facility, and not be transferred or discharged unless:

    A. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

    B. The resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.

    C. The safety and/or health of others in the facility are endangered.

    D. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare and Medicaid) a stay at the facility.

E. All information, including reasons, pertaining to the transfer or discharge must be documented in the clinical record.

F. NOTICE BEFORE TRANSFER...before a facility transfers or discharges a resident, personnel must notify the resident and, if known, a family member or legal representatives as to the location of the transfer.

G. Notice will be given at least THIRTY DAYS in advance, except in cases of emergency or risk of personal safety of the resident or others. The resident and/or legal representatives will be informed as to the location to which he/she is being transferred. The resident has the right to appeal the decision.

H. The facility will provide sufficient preparation and orientation to ensure a safe and orderly transfer.

I. A written notice of the bed-hold policy and readmission must be provided to the resident and a family member or legal representative before a resident is transferred to a hospital or allowed to go on therapeutic leave.

25. RIGHT TO BE FREE OF CHEMICAL OR PHYSICAL RESTRAINT...the resident has the right to be free from physical restraints and psychoactive drugs that are used for convenience of the staff and not required to treat the resident's medical symptoms.

Example:
John Doe becomes restless and begins to pace in the hall several hours each day. Some staff members are upset because John refuses to go to bed at the "right" time. They want the physician to order a tranquilizer or allow them to use a waist restraint to keep him in bed.

26. RIGHT TO BE FREE OF ABUSE...resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. Any instances of such abuses must be thoroughly investigated and reported to the Division of Aging.

A. There must be written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of residents' properties. The facility must:

1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

2) Not employ individuals who have been found guilty of abusing, neglecting, or mistreating individuals by a court of law or have had a finding entered into the state nurse assistant registry concerning abuse, neglect, and mistreatment of residents or misappropriation of their properties.

3) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse assistant.

B. The facility must report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident's property immediately to the administrator of the facility.

C. There must be evidence that all alleged violations are thoroughly investigated.

D. Within five (5) working days, all investigations must be reported to the administrator or his/her designated representative and to other officials in accordance with state laws.

Examples:
"Shut up and help me get your clothes on!", "You have wet your pants again!", and "Eat your supper or you won't get a cigarette tonight." after which the resident was withdrawn and crying are all examples of verbal abuse.

While giving personal care, a nurse assistant makes fun of and plays with the genitals of the resident. This is an example of sexual abuse.

A resident refuses to get up from her chair to go to the shower room. The angry nurse assistant grabs the resident forcefully from the chair which causes pain in both of the resident's arms. This is physical abuse, even if no visible injury occurs. While some behavior may not be considered abuse, the nurse assistant must treat all residents with respect.

Teasing a resident, hiding his/her possessions, ignoring, or neglecting him/her with a resultant feeling of sadness for the resident, loss of self-esteem, anger, frustration, etc., are all instances of mental abuse.

Striking a resident with a ruler for "misbehavior" is an example of corporal punishment.

Shutting a resident in a room alone, against his or her will, is an example of involuntary seclusion.

27. RIGHT TO QUALITY OF LIFE...care must be provided in a manner and in an environment that promotes maintenance and enhancement of each resident's quality of life.

Example:
It is not usually enough to keep a resident clean and well-fed. Residents' lives can be enhanced in many ways by special acts performed by nurse assistants. Putting make-up on residents that were accustomed to that in their normal routine, using perfume or after-shave, tuning the radio or TV to a favorite program, and discussing current events with them while giving care are just a few of the ways that "quality" can be added to life.

28. RIGHT TO DIGNITY...care must be provided in a manner and in an environment that maintains or enhances each resident's dignity.

Example:
Calling each resident by the name he or she prefers, speaking directly to the resident in a pleasant tone of voice, and smiling while you converse all contribute to the feeling of dignity. Having the resident's room in good order with home-like touches (photos, favorite ornaments, etc.) also assures this right.

29. RIGHT TO SELF-DETERMINATION...the resident has the right to choose activities, schedules, and health care consistent with his/her plan of care. The resident has the right to interact with members of the community both inside and outside of the facility and to make significant choices about life in the facility.

    Example:
    Having choices in daily life is important to everyone. Residents must be given the opportunity to choose as often as possible. What clothes they will wear, activities to attend, foods they will eat, with whom they will visit, and when they will leave the facility for visits are among the choices they may make.

30. RIGHT TO PARTICIPATE IN RESIDENT AND FAMILY GROUPS...the resident has the right to participate in and organize groups in the facility. These groups have the right to meet in private. Staff or visitors may attend the meetings at the group's invitation. A specific person must be responsible for providing assistance and responding to written requests that result from the meeting. The facility must listen to the group's views and act on the grievances and recommendations presented.

    Example:
    A group of residents want to meet to discuss improvements they would like to see in the meals they are served. Not only may they meet in the facility in private, but the facility is obligated to listen to their views and act upon their suggestions.

31. RIGHT TO PARTICIPATE IN OTHER ACTIVITIES: SOCIAL, RELIGIOUS, AND COMMUNITY...resident may participate in any activity that does not interfere with rights of other residents of the facility.

    Example:
    John Doe is a member of the ELKS Lodge. He may go out of the facility for the meetings of this group. Mary Doe belongs to the Seniors Sunday School class at a local church. They both may go out to their meetings as long as they are able to make the trips.

32. THE RIGHT TO AN ONGOING PROGRAM OF ACTIVITIES designed to meet in accordance with the comprehensive assessment, the interest, and the physical, mental, and psychosocial well-being of each resident.

33. THE RIGHT TO MEDICALLY RELATED SOCIAL SERVICES which assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

PATIENT SELF-DETERMINATION ACT

The Patient Self-Determination Act sponsored by Senator John Danforth of Missouri went into effect on December 1, 1991.

This act requires some health care organizations to provide written information to patients or residents about their rights under state law to make their own medical care decisions. These rights include the patients/residents right to refuse medical treatment and formulate advance directives.

Advance Directives

An advanced directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law. This written directive relates to the provision of medical care when the individual is incapacitated.

Living Will

Missouri's Living Will Law allows a person (the declarant) to direct his/her doctor and medical facility (hospital, long-term care facility, etc.) to withhold or withdraw medical procedures that merely prolong the dying process.

The living will must be in writing, dated, and signed by the declarant or by a person other than the declarant at the declarant's express direction. If the living will is not in the declarant's handwriting, it must be witnessed by two persons.

Anyone making a living will should always keep the original and give copies to his/her doctor, hospital, long-term care facility, etc. (for inclusion in the medical files), and family members.

The living will can be revoked in any manner by which the declarant can show he or she wants to revoke it. The living will becomes effective only when the declarant is suffering from a terminal condition and is no longer able to make and communicate treatment decisions.

Durable Power of Attorney for Health Care

Missouri's recently enacted legislation provides citizens with a statutory right to designate others to make health care decisions for them if they become incapacitated.

The person you designate to make decisions for you may be any adult you trust to make important decisions for you, other than an attending physician or the owner/operator or employee of a health care facility where the patient is a resident.

The durable power of attorney for health care must be in writing, signed by the patient/resident, and notarized. It comes into effect only upon a certification of incapacity by two licensed physicians unless the document provides for a different number. In any event, certification by at least one physician is required. The durable power of attorney for health care may be revoked by a competent patient/resident at any time and in any manner.

Under the durable power of attorney for health care, the person designated to make these decisions may make every possible decision regarding health care. This includes decisions to enter a hospital, to undergo an operation, and even to terminate life-support systems. However, if you want to enable your designated decision maker to authorize the withdrawing or withholding of food and water, the document must provide a specific grant of authority to do so.

ABUSE AND NEGLECT REPORTING

The Omnibus Nursing Home Act includes a section regarding the reporting of abuse or neglect. Section 198.070

1. Beginning January 1, 1980, mandated reporters shall report abuse and neglect immediately or cause a report on abuse and neglect to be made to the Department of Social Services. The mandated reporters include any physician, dentist, chiropractor, optometrist, podiatrist, intern, nurse, medical examiner, social worker, psychologist, minister, Christian science practitioner, peace officer, pharmacist, physical therapist, facility administrator, activities director, nurse's assistant, or orderly in facility or employee of the Department of Social Services or of the Department of Mental Health.

2. The report shall contain the name and address of the facility, the name of the resident, information regarding the nature of the abuse or neglect, the name of the complainant, and any other information which might be helpful in an investigation.

3. If a mandated reporter fails to report or cause a report to be made, he or she could be found guilty of an infraction and fined up to $200.00.

4. Any other person having reasonable cause to believe that a resident has been abused or neglected may report such information to the Department.

5. All reports should be made to the Division of Aging Elderly Abuse and Neglect Hot Line. The toll-free telephone number is 1-800-392-0210.

6. Upon receipt of a report, the Department shall initiate an investigation within 24 hours.

7. If the Department has reasonable cause to believe that immediate removal of the resident is necessary to protect the resident from abuse or neglect, the Department or local prosecuting attorney may file a petition for temporary care and protection of the resident in a circuit court. The circuit court may issue an ex parte order granting the temporary care for a period not to exceed 30 days.

8. Reports shall be confidential and shall not be deemed a public record and shall not be subject to the provisions of section 109.180, RSMo, chapter 610, RSMo. The name of the complainant or any person mentioned in the reports shall not be disclosed unless:

    a. the complainant or the resident mentioned agrees to disclosure;

    b. the Department determines disclosure of a resident's name is necessary to prevent further abuse or neglect of the resident;

    c. the Department determines that disclosure of the name of the facility employee is necessary to prevent further abuse or neglect;

    d. release of a name is required for conformance with a valid subpoena or in connection with a review by the administrative hearing commission.

9. Anyone who makes a report of abuse or neglect or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability unless the report was made in bad faith or with malicious purpose.

10. No person who directs or exercises any authority in a facility shall evict, harass, dismiss, or retaliate against a resident or employee because he/she or any member of his/her family has made a report of any violation or suspected violation of laws, ordinances, or regulations applying to the facility which he/she has reasonable cause to believe has been committed or has occurred.

11. Any person who knowingly abuses or neglects a resident of a facility shall be guilty of a class D felony.

12. The Department shall maintain a record of the names of any persons who have been determined by the Department to have knowingly abused or neglected a resident while employed in any facility. The Department shall not include any name in such record until after an investigation of the allegation has been made and the person alleged to have knowingly abused or neglected a resident has been notified in writing mailed to the last known address of the person.

    The person will be informed that an allegation has been made and that an investigation tends to substantiate the allegation. The person will also be informed that his/her name will be included in the record of the Department as having knowingly abused or neglected a resident and the consequences of being so listed. The person has a right to challenge the allegation. If no reply has been received within thirty days of mailing the notice, the Department may include the name of each person in its record. If the person so notified wishes to challenge the allegation, he/she may file an application for a hearing with the Department. The Department shall grant the application within thirty days after receipt by the Department and set the matter for hearing. The hearing shall be conducted in the county of the person's residence by the Director of the Division of Aging or his/her designee. The person appealing such an action shall be entitled to be present at the hearing, in person and by attorney or representative, and shall be entitled to introduce into the record of such hearing any and all evidence, by witnesses or otherwise.

    The Director of the Division of Aging shall review all of the evidence in the appeal record and shall determine whether the person knowingly abused or neglected a resident. The Director of the Division of Aging shall include a statement of finding pertinent to the questions of issue. If the person fails to appeal the Department's findings, those findings shall constitute a final determination that the person has knowingly abused or neglected a resident.

13. Any person who disagrees with the decision made by the Director of the Division of Aging may appeal to the circuit court of the county in which such person resides within ninety (90) days from the date of the action and decision appealed from. Section 198.070.13 explains how to file the appeal with the circuit court.

14. The Division of Aging will provide licensed operators with the names of persons who knowingly abused or neglected a resident. No operator shall knowingly employ any person who has been determined to have knowingly abused or neglected a resident and whose name is listed in the records maintained by the Division of Aging.

LESSON PLAN: 4

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

SCOPE OF UNIT:

This unit is about how to chart accurately on the medical record; how to communicate effectively; how to make accurate observations about the clients and what to do with the information; how to use a care plan; basic telephone techniques; and measurements used in the health care field.

INFORMATION TOPIC: II-4 OR DEMONSTRATION:

COMMUNICATION SKILLS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with their correct definitions.
2. Identify the five elements of communication.
3. Explain the difference between verbal and nonverbal communication.
4. Identify factors that promote effective communication.
5. Identify the correct way to answer the telephone.
6. Identify the difference between hearing and listening.
7. Identify barriers that prevent effective communication.
8. List conditions that a client may have that makes communicating with him/her difficult.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Showing Effective Communication and Using Verbal Skills
2. HO 2: How to Be a Good Listener
3. HO 3: Check Your Listening Skills
4. HO 4: Rate Your Communication Skills

5. HO 5: Types of Hearing Aids

6. HO 6: Operation of a Hearing Aid

7. HO 7: Communicating with the Aphasic Client

8. Communicate Like a Pro, video #R89, available from the Missouri Vocational Resource Center, 15 min.

9. Audiovisuals available from the Missouri Division of Aging Film Library

   a. A Gift from Mrs. Timm, video (TF #27), 16 min.
   b. Are You Really Listening? video (TF #170), 15 min.
   c. Assertiveness Training, Vol. I (TF #150A) and II (TF #150B) videos, 90 min. each
   d. Perception, video (TF #30), 28 min.
   e. Hands of Love, video (TF #166), 60 min.
   f. Minnie Remembers, 16mm film (TF #25), 8 min.
   g. Peege, video (TF #73), 28 min.
   h. Overcoming Language Barriers, video (TF #9G), 22 min.
   i. Beyond Language, video (TF #9I), 20 min.
   j. How to Listen Powerfully, audiotape (TT #44), 4 tape series
   k. Resolving Conflicts, Clashes, and Flare-ups at Work, audiotape (TT #9), 1 tape

10. Slide projector

11. Television and VCR

12. Tape player

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 4 (Student Reference page 55) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 9.

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Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 1, Section 4.

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INTRODUCTION:

One of the most important responsibilities and functions of the health care assistant is to communicate well with clients, families of clients, visitors, and coworkers. This is not always easy. Communication is simply an exchange of information which involves a sender (speaker) and a receiver (listener). To be effective, the message must be understood by both parties involved. Communication is a means by which you and your clients reach each other. You must allow the client to talk to you and listen very carefully to what he/she is saying. There are two types of communication: verbal and nonverbal. We will discuss these, as well as how to become more effective as a communicator.

LESSON PLAN: 4
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

OUTLINE:

I. Terms and Definitions **(II-1)**

- A. Communication - the exchange of information accomplished by sending and receiving messages, resulting in understanding between the sender and the receiver
- B. Aphasia - language difficulty, due to brain damage, which can affect listening, speaking, reading, and writing skills
- C. Constructive criticism - criticism offered in a way that is acceptable and helpful
- D. Criticize - to find fault with someone or something
- E. Daydream - to let the mind wander
- F. Distractions - actions or noises around an individual that make it difficult for him/her to pay attention
- G. Empathy - identification with, and understanding of, another's situation, feelings, or motives
- H. Feedback - the return of a portion of the information sent; a reply that shows the message was received
- I. Jargon - specialized or technical language of a trade, a profession, or a group of people
- J. Listen - to pay attention in order to hear
- K. Nonverbal communication - messages sent and received through gestures, facial expressions, posture, and dress/appearance
- L. Slang - nonstandard vocabulary used and understood by a small group of people. Slang is often considered incorrect and sloppy
- M. Verbal communication - messages transmitted through the use of spoken words

II. The Five Elements of Communication **(II-2)**

- A. Sender (speaker)
  - 1. Source of information
  - 2. May be a person or inanimate object like a TV or radio
- B. Message - the information which is to be sent
- C. Channel of transmission
  - 1. If the message is spoken, it travels by sound waves to the listener.
  - 2. If the message is written or gestured, it requires light to be seen.
- D. Receiver (listener) - someone or something "hears" the message
- E. Response
  - 1. A person tries to understand and respond to the message.
  - 2. If the receiver is a machine, its response may be a click.

III. Verbal and Nonverbal Communication **(II-3)**

- A. Verbal communication is getting a message across through the use of words by speaking them. There are several types of verbal communication:
  - 1. Greeting clients and visitors
  - 2. Delivering and receiving messages
  - 3. Carrying on conversations
  - 4. Answering telephone
- B. Nonverbal communication is getting a message across without the use of words; expressing feelings or emotions in other ways. Nonverbal communication is used almost 100% of the time. There are several types of nonverbal communication: **(II-4)**
  - 1. Facial expressions - smile; frown; twist of the mouth; raised eyebrows
  - 2. Gestures and body movements - a shrug of the shoulders; hand movements
  - 3. Posture of the body - hunching over; standing straight
  - 4. Tone of voice - sarcastic; friendly

5. Smells - the odor of stool; fragrance of cologne

6. Space - the distance between two people as they talk; how close a health care assistant gets to the client

7. Silence - approving; sympathetic; hostile

8. Touch - gentle; rough; conveys friendliness and affection

9. Receiving nonverbal communication

    a. Watch facial expressions.

    b. Study body movements and try to interpret their meaning (shifting, wringing hands).

    c. Watch for and interpret language "extras" (laughing, coughing, yawning).

    d. Notice clothing and jewelry to determine the person's mood and self-confidence.

    e. Be very careful not to over generalize and draw a wrong conclusion about a person based on his/her nonverbal communication.

10. Sending nonverbal communication.

    a. Use your body when talking - do not stand still and stiff.

    b. Do not be afraid to shake hands when greeting someone.

    c. Use your face to show pleasant feelings: smile.

    d. Be neat and clean; dress tastefully.

    e. Stand or sit at a comfortable distance.

    f. Include everyone in a discussion, even if you receive feedback from just one member of the group.

    g. When you talk with groups of people, do not flirt with members of the opposite sex. You may score points with that person, but you will lose the interest, attention, and patience of the others.

    h. Make the message your body sends the same as the one your words send.

    i. Good rule to follow: keep your hands below your neckline. Avoid playing with your hair, face, and neck.

IV. How to Communicate Effectively (HO 1) **(II-5)**

A. Introduce yourself frequently.

B. Show an interest in talking with the client. Speak clearly with a pleasant voice.

C. Allow time for talking.

D. Pace yourself to the speed at which the client talks.

E. Try to get at the client's eye level and stay within sight. Maintain eye contact.

F. Remember, when you communicate you are not only conveying words but also your attitudes and feelings about yourself and others.

G. If communication is not taking place, explore the reasons why.

H. Reminiscence is a form of communication for the elderly.

  1. A way of reviewing life; helps in a search for meaning, helps increase or regain self-esteem, and can even help the client prepare for death.

  2. Listen to his/her stories--this allows the client to feel he/she is leaving wisdom or insight to the young and validates that he/she had a meaningful life.

I. Pets may aid in communication.

J. Be positive; it is better to say what you can do rather than what you cannot do.

V. Telephone Communication **(II-6)**

A. When you answer the phone, you represent the facility.

B. Be tactful, diplomatic, and friendly.

C. Speak in a moderate tone using clear and distinct words.

D. Answer the phone by the second ring.

E. Identify yourself and the facility. Example: Good afternoon, Belgrade Nursing Home, Miss Alton speaking, May I help you?

F. Listen carefully to what the caller is saying to make sure you understand the request.

G. Give the caller your undivided attention.

    1. Do not talk to others while taking a call.

    2. Do not pick up the telephone and answer when you are finishing another conversation.

    3. Do not cough, clear your throat, or blow your nose while talking on the phone.

H. When the caller asks to speak to a specific person:

    1. Tell the caller you are placing him/her on hold. If not, put the phone down, or cover the mouthpiece with your hand.

    2. Take a message if the person is out or busy. Be sure the message is received.

I. Keep paper and pencil by phone.

J. When taking a message:

    1. Take down all necessary information.

        a. Name of caller (Ask caller to spell his/her name.)

        b. Area code and phone number

        c. Date and time of call

    2. Read the message to the caller to verify the information.

    3. Thank the person for calling.

    4. Initial message.

K. If you put a person on hold, get back with the caller as soon as possible and apologize for having him/her wait.

L. Generally, staff members are not to make or accept personal calls while on duty.

VI. How Hearing and Listening Differ (II-7)

A. Hearing is a passive awareness of sound.

B. Listening is an active, intentional effort to hear the message and understand its meaning.

C. Nursing action (HOs 2 & 3)

1. Requires concentration and close attention to what is being said and done.
2. Have direct eye contact with the person who is speaking.
3. Be alert when listening.
4. Try to put aside your own prejudices and values.

VII. Barriers that Prevent Communication **(II-8)**

A. Changing the subject

B. Giving your own opinion about the person and his/her situation without being asked

C. Belittling a person's feelings

D. Seeming to be too busy

E. Jumping to conclusions before you know the entire story

F. Giving false or inappropriate reassurances

G. Causing fear of an unpleasant response

H. Interrupting frequently

I. Not waiting long enough for a reply (elderly people are slower to respond)

J. Words that sound alike (homonyms) may have a different meaning to the receiver than was intended by the sender.

1. A "plane" is a flying vehicle.
2. A "plain" is a wide, open field.

K. Meanings of words sometimes change from one generation to another.

VIII. Clients with Communication Difficulties **(II-9)**

A. Deafness

1. Signs indicating hearing loss

   a. Loss of interest in group activity, in other persons, or in what is being said to him/her

        b. Apparent disregard for directions or suggestions

        c. An attempt to lip-read

    2. Encourage the client to use a hearing aid and give him/her time to adjust it. (HOs 5 & 6)

    3. Face the client in a lighted area; stand where he/she can see you.

    4. Use moderate tone of voice; do not shout at the client.

    5. Reduce background noise.

    6. Attempt to learn some sign language.

B. Blindness

    1. Observe for signs indicating deteriorating eyesight.

        a. Stumbling or falling; holding on to objects when walking

        b. Using touch to find personal things

    2. Encourage use of eyeglasses.

    3. Use verbal communication if client can hear; use normal tone of voice.

    4. Use touch.

    5. Identify self when entering or leaving a room.

    6. Keep surroundings the same--do not rearrange personal items or furniture without informing client.

C. Speech disorders (HO 7)

    1. Dysarthria - weakness or paralysis of muscles of lips, tongue, and throat; may be due to brain damage from stroke or accident

    2. Aphasia - language disorder in which client has difficulty understanding words and using them correctly due to damage of the part of the brain that controls speech

        a. Expressive - client has difficulty saying what he/she is thinking and wants to say; may also have trouble writing and making gestures to act out what he/she is trying to say

        b. Receptive - client cannot understand what is being said to him/her; gestures and pantomime may confuse him/her; may have difficulty understanding what he/she is reading or recognizing the words being read

3. How to communicate to client with speech disorder:

   a. Encourage client to express self in any way possible.

   b. Continue to talk to the client and encourage others to also.

   c. Use short, simple sentences and use the same words each time when you give directions.

   d. Watch the client for gestures or body movements that he/she may be communicating with.

   e. Be patient, do not speak for the client, although you may want to help him/her with words he/she is having difficulty with.

   f. Do not talk with another person in front of the client if he/she cannot understand.

   g. Remember the client is still considered an adult.

   h. Remember the basic principles of effective communication.

IX. Summary and Conclusion

A. Terms and definitions

B. The five elements of communication

C. Verbal and nonverbal communication

D. How to communicate effectively

E. Telephone communication

F. How hearing and listening differ

G. Barriers that prevent communication

H. Clients with communication difficulties

Remember, in order to be of help, you must learn to communicate with your clients. If at any time you have difficulty, try to determine the cause of the lack of communication. Review the information in this lesson often to keep yourself aware of the basic principles. Your effective communication skills are invaluable to both you and others. The next lesson is on the care plan.

LESSON PLAN: 4

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. **How do you define the terms: communication, aphasia, constructive criticism, criticize, day dream, distractions, empathy, feedback, jargon, listen, nonverbal communication, verbal communication, and slang?**

2. **What are the five elements of communication?**

3. **How do verbal and nonverbal communication differ?**

4. **What are the eight types of nonverbal communications?**

5. **How can the health care assistant communicate effectively with the client?**

6. **How do you answer a telephone?**

7. **How do hearing and listening differ?**

8. **What barriers prevent communication?**

9. **What conditions which the client may have could result in communication difficulties?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES

1. **Show audiovisuals.**

2. **Have class members choose a partner; then have them talk nose to nose, then 15 inches away from one another, and then back to back. This exercise helps them to understand concept of "personal space". Discuss how they felt when talking from various distances.**

3. **Mr. Joseph's wife calls. She is upset because Mr. Joseph appears unshaven. How should you answer the phone and communicate with her?**

4. **Show and discuss communication boards.**

5. **Have students complete HOs 3 and 4. Discuss their answers.**

ANSWERS TO EVALUATION ITEMS:

1. d
2. g
3. b
4. f
5. a
6. e
7. d
8. b
9. d
10. b
11. Hearing
12. Listening
13. a
14. blindness, deafness, speech disorders
15. T
16. F
17. T
18. T
19. T
20. T
21. T
22. 1
23. 1
24. 2
25. 1
26. 2
27. 2
28. 2

LESSON PLAN: 4

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

EVALUATION ITEMS:

Match the terms in Column I with the correct definition in Column II.

____ 1. Communication

____ 2. Nonverbal communication

____ 3. Verbal communication

____ 4. Slang

____ 5. Aphasia

____ 6. Listen

a. Language difficulty, due to brain damage, which can affect listening, speaking, reading and writing skills

b. Messages transmitted through the use of spoken words

c. To let the mind wander

d. The exchange of information accomplished by sending and receiving messages, resulting in understanding between the sender and the receiver

e. To pay attention in order to hear

f. Nonstandard vocabulary used and understood by a small group of people

g. Messages sent and received through gestures, facial expressions, posture, and dress/appearance

7. Which one of the following includes all of the elements of communication? (Circle the letter of the best answer.)

   a. Smells, space, silence, and touch
   b. Facial expressions, gestures, posture of body, and tone of voice
   c. Delivering and receiving messages and answering the telephone
   d. Sender, message, channel of transmission, receiver, and response

8. Verbal communication is: (Circle the letter of the best answer.)

   a. Using touch to send a message.
   b. Sending a message using words.
   c. The same as nonverbal communication.
   d. Sending a message without the use of words.

9. An example of effective communication is: (Circle the letter of the best answer.)

   a. Speaking loudly so the client can hear you.
   b. Talking fast so no one can interrupt you.
   c. The use of slang to get your point across.
   d. Maintaining eye contact with the client.

10. Which of the following are correct techniques for answering the telephone? (Circle the letter of the best answer.)

   a. Tell the caller the charge nurse is busy and to call back later.
   b. Identify yourself and the facility.
   c. Tell the caller you are too busy to take a message.
   d. Identify the facility but do not give your name.

11. ________________ is a passive awareness of sound.

12. ________________ is an active, intentional effort to hear the message and understand its meaning.

13. All of the following are barriers that prevent communications except one. Which one is not a barrier to communications? (Circle the letter of the best answer.)

   a. Showing that you have time to listen to the client and you care
   b. Giving false or inappropriate reassurance to the client so they will feel better
   c. Interrupting the client frequently because they are talking slowly
   d. Telling the client to hurry up and reply, that you don't have all day

14. List three conditions that a client may have that makes communication difficult.

   a.
   b.
   c.

For each of the following, write "T" if the statement is true or "F" if it is false.

___ 15. There must be a sender and a receiver for communication to take place.

___ 16. Reminiscence is not a form of communication.

___ 17. Hearing is a passive awareness of sound; whereas, listening is an active intentional effort to hear the message and understand its meaning.

___ 18. An apparent disregard for directions or suggestions may be a sign of deafness.

___ 19. A person with a speech problem may know what he or she wants to say but is unable to say it.

___ 20. It is important to use the nonverbal communication technique of touching when communicating with the blind client.

___ 21. Always look directly at the client who is speaking to you.

On the line provided write 1 if the statement is a barrier to communication or a 2 if it is an effective way to communicate.

___ 22. Belittling a person's feelings

___ 23. Changing the subject

___ 24. Showing an interest in discussion

___ 25. Seeming to be too busy

___ 26. Listening

___ 27. Staying within sight of the client at eye level

___ 28. Pacing yourself to the speed at which the client talks

HO 1

SHOWING EFFECTIVE COMMUNICATION AND USING VERBAL SKILLS

It is important for others to understand what you want to say, but you must first understand what is being said to you.

1. Listening is how you understand what is said to you. Good listening takes work.

   a. STEP ONE: Look into the speaker's eyes. This lets the speaker know that you think what he or she is saying is important and lets you see the emotion behind what is being said.

   b. STEP TWO: Block out any distractions. Concentrate on what is being said. Block out other thoughts, feelings or noises.

   c. STEP THREE: Don't close your mind before the conversation begins. Sometimes we close our minds because of a trait the speaker has or because we don't like the speaker. When you close your mind, you don't listen and don't communicate.

   d. STEP FOUR: Don't daydream. Daydreaming is the opposite of concentration. To listen well, you must concentrate.

   e. STEP FIVE: Don't plan a reply while listening. While you think of a reply, you may miss what is being said, even though you hear the speaker's voice.

2. "Feedback" is the responses you give a speaker in a conversation. Feedback lets the speaker know his or her message is understood. Feedback is needed because what is being said and what is being understood may be two different things.

3. "Positive" feedback means showing the speaker you are interested in what he or she is saying. Here are some ways to give positive feedback?

   a. Don't interrupt the speaker.

   b. Sit (or stand) up straight and lean slightly forward.

   c. Keep your eyes open.

   d. Don't fidget or look at your watch.

   e. Smile or laugh when the speaker makes a joke.

   f. Ask questions and say things that further the conversation.

   - Sometimes a question makes the message more clear. For example, "Do you mean the Carl of Carl's Deli?" or "Did you mean the Wednesday of last week or this coming week?"

   - Sometimes a question helps you get more information. For example, "Where can I find that form?" or "Under which heading is that article filed?"

   g. Repeat or rephrase the message in the way you understood it. Often when you say how you understood the message, you reveal a misunderstanding quickly. You separate the message from the way it was understood.

For example: "In other words, you want the salad on that table, right?"

h. Reveal information that is important to the conversation. Don't add unneeded detail.

4. Conversation Techniques

Effective communication requires you to state a message in a way that does not distract from the message itself. As a speaker, you do not want your listener to misunderstand your message because of the way it is expressed.

a. STEP ONE: Use names in conversation. When you use his or her name, the person feels more comfortable.

- Use the name in an introduction. For example, "John, this is Harry. Harry is a friend of mine from..." "Hello, Harry. It is nice to meet you. Do you work around here, Harry?"

- Use the name while talking. For example, "That's a good idea, Charlotte." "We could go over to Sue's house later."

- Use the name at the end of the conversation. For example, "It was nice to meet you, Gary." "See you around, Doug."

b. STEP TWO: Don't be overbearing. Give the person you are talking to a chance to speak. By letting the other person take a turn, you receive valuable feedback and learn how to make your message more clear.

c. STEP THREE: Don't send unclear or vague messages. Words that may lead to vague and unclear messages are: always, everybody, sometimes, often, never, nobody and everything.

d. STEP FOUR: Use the correct level and tone of voice. Your voice's tone and level influence how your listener perceives the message you are sending.

If your voice is loud or harsh, the listener may think you are angry. If your voice is soft, the listener may think you are unsure of what your are saying.

e. STEP FIVE: Say "no" politely.

- Center your "no" on a thing, not a person so others do not take the "no" personally. For example, you should say, "The problem with your car seems to be a lack of gas," not "You didn't get gas; that is why the car won't run."

- Say what you can do and imply what you can't do. For example, you are asked to complete a task in two hours. Don't say, "I can't do that." Say, "I'll need three hours to do the job right."

- Imply the negative, rather than stating bluntly. For example, "this copier is used for company business," is better than, "don't use this copier for your own stuff."

f. STEP SIX: Ask questions, even when you are the speaker. Sometimes your listener will not know what to ask you (the speaker) about the message. Ask specific questions that let your listener know what the main point is.

HO 2

HOW TO BE A GOOD LISTENER

1. STOP TALKING!
   You cannot listen if you are talking.

2. PUT THE SPEAKER AT EASE.
   Help the speaker feel free to talk. Provide what is often called a "permissive environment."

3. SHOW THE SPEAKER THAT YOU WANT TO LISTEN.
   Look and act interested. Do not read your mail while someone is talking. Listen to understand rather than to reply.

4. REMOVE DISTRACTIONS.
   Don't doodle, tap, or shuffle papers. Shut the door if it will be quieter.

5. EMPATHIZE WITH THE SPEAKER.
   Try to put yourself in the speaker's place so that you can see the point of view.

6. BE PATIENT.
   Allow plenty of time. Do not interrupt. Do not start for the door or walk away.

7. HOLD YOUR TEMPER.
   An angry person gets the wrong meaning from words.

8. GO EASY ON ARGUMENT AND CRITICISM.
   Do not put the speaker on the defensive. The speaker may "clam up" or get angry. Try not to argue; even if you win, you lose!

9. ASK QUESTIONS.
   Encourage the speaker and show you are listening. Questions also help to develop further points.

10. STOP TALKING!
    This is first and last, because all other listening skills depend upon it. You just can't do a good listening job while you are talking.

Nature gave people two ears but only one tongue, which is a gentle hint that listening is more important than talking!

Major benefits of good listening are:

- A good listener can make better decisions.
- A good listener saves time.
- Listening helps the speaker determine how well the message is being received.
- A good listener stimulates others to better speaking.
- Good listening decreases misunderstanding.

HO 3

CHECK YOUR LISTENING SKILLS

Directions: Check your listening skills by answering the following questions.

Do you:

____ 1. Want to remember what is being said?

____ 2. Have an interest in the opinions of others?

____ 3. Give the speaker your attention?

____ 4. Face the speaker?

____ 5. Show facial expressions as feedback?

____ 6. Achieve eye contact?

____ 7. Keep an open mind?

____ 8. Allow the speaker to finish his/her speech without interruptions?

____ 9. Listen for main ideas: "My main point is...?"

____ 10. Recognize key phrases: "My main criticism is...?"

____ 11. Make an attempt to shut out other noises and distractions?

____ 12. Try to concentrate on what is being said?

____ 13. Anticipate what the speaker is going to say?

____ 14. Mentally summarize what the speaker has said?

HO 4

RATE YOUR COMMUNICATION SKILLS

Your ability to communicate is important on the job. Communication requires skill in two directions - you have to be able to make the other person understand what you want to say, and you have to listen carefully so that you can understand what the other person is saying. You must be able to express yourself clearly in writing and be able to read and understand letters, instructions and other written matter.

Directions: Rate yourself on the communication skills that follow, using this point scale:

Excellent	5 points
Good	4 points
Average	3 points
Fair	2 points
Poor	1 point

Do you:

____ 1. Have a pleasant speaking voice, pitched neither too low nor too high?

____ 2. Speak at a moderate rate, neither too fast nor too slow?

____ 3. Speak loudly enough so that you can be heard comfortably?

____ 4. Avoid speaking in an affected, overly dramatic manner?

____ 5. Avoid saying "er" too often?

____ 6. Pronounce each word correctly and clearly?

____ 7. Write and speak in complete sentences?

____ 8. Speak and write so that the verb agrees with the subject?

____ 9. Punctuate so that the meaning of the sentence is clear?

____ 10. Limit the use of slang?

____ 11. Understand that the use of profanity is offensive to many?

____ 12. Organize your thoughts so that you can write and speak in a logical manner?

____ 13. Refrain from interrupting others while they are speaking?

____ 14. Listen to what the other person is saying, instead of planning what you are going to say next?

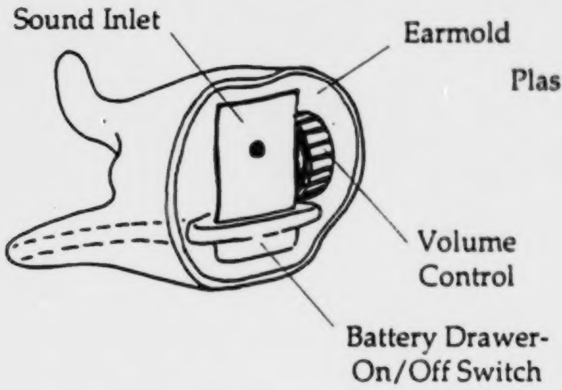
____ 15. Know when you have said enough?

Those items that you rated 3 or below are the ones that you need to improve.

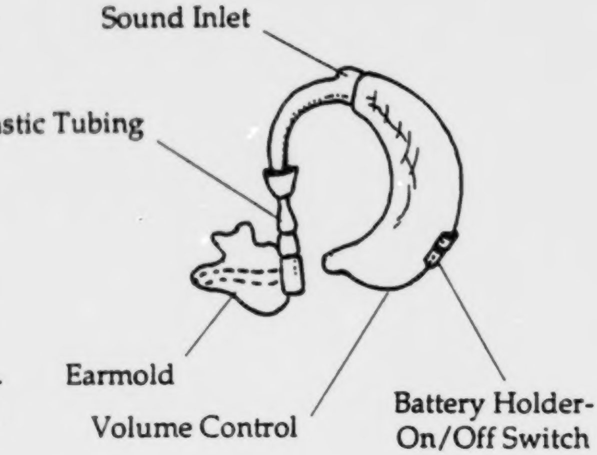
HO 5

TYPES OF HEARING AIDS

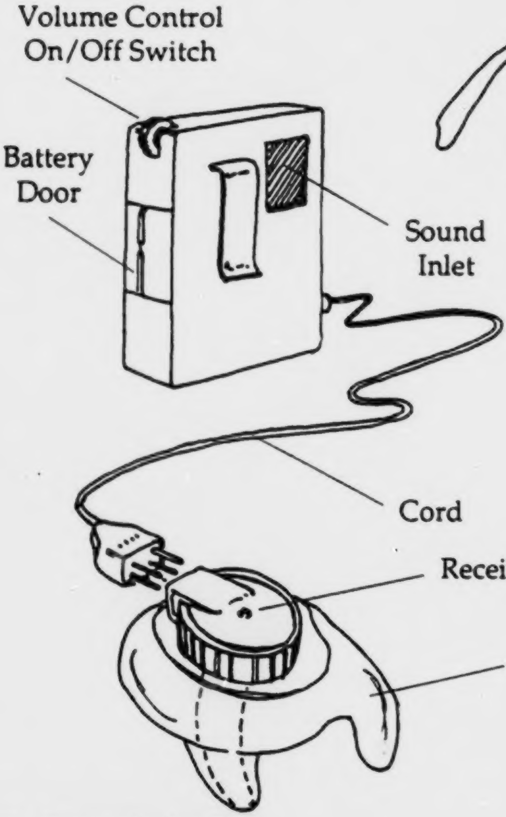
In the Ear


Sound Inlet
Earmold
Volume Control
Battery Drawer-On/Off Switch

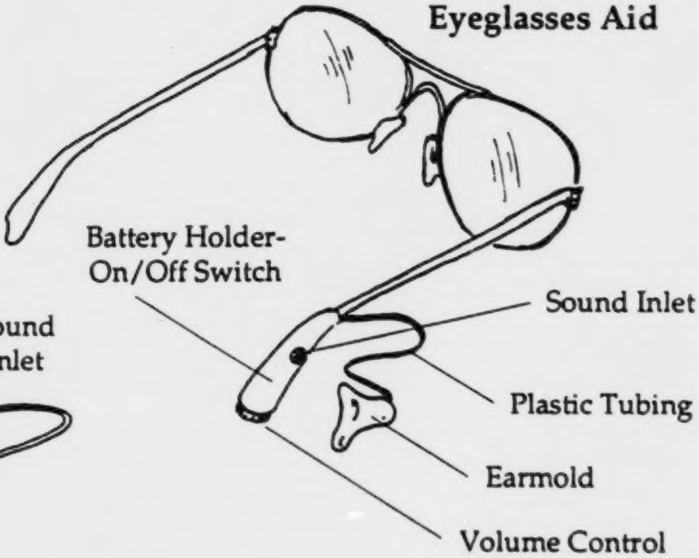
Behind the Ear


Sound Inlet
Plastic Tubing
Earmold
Volume Control
Battery Holder-On/Off Switch

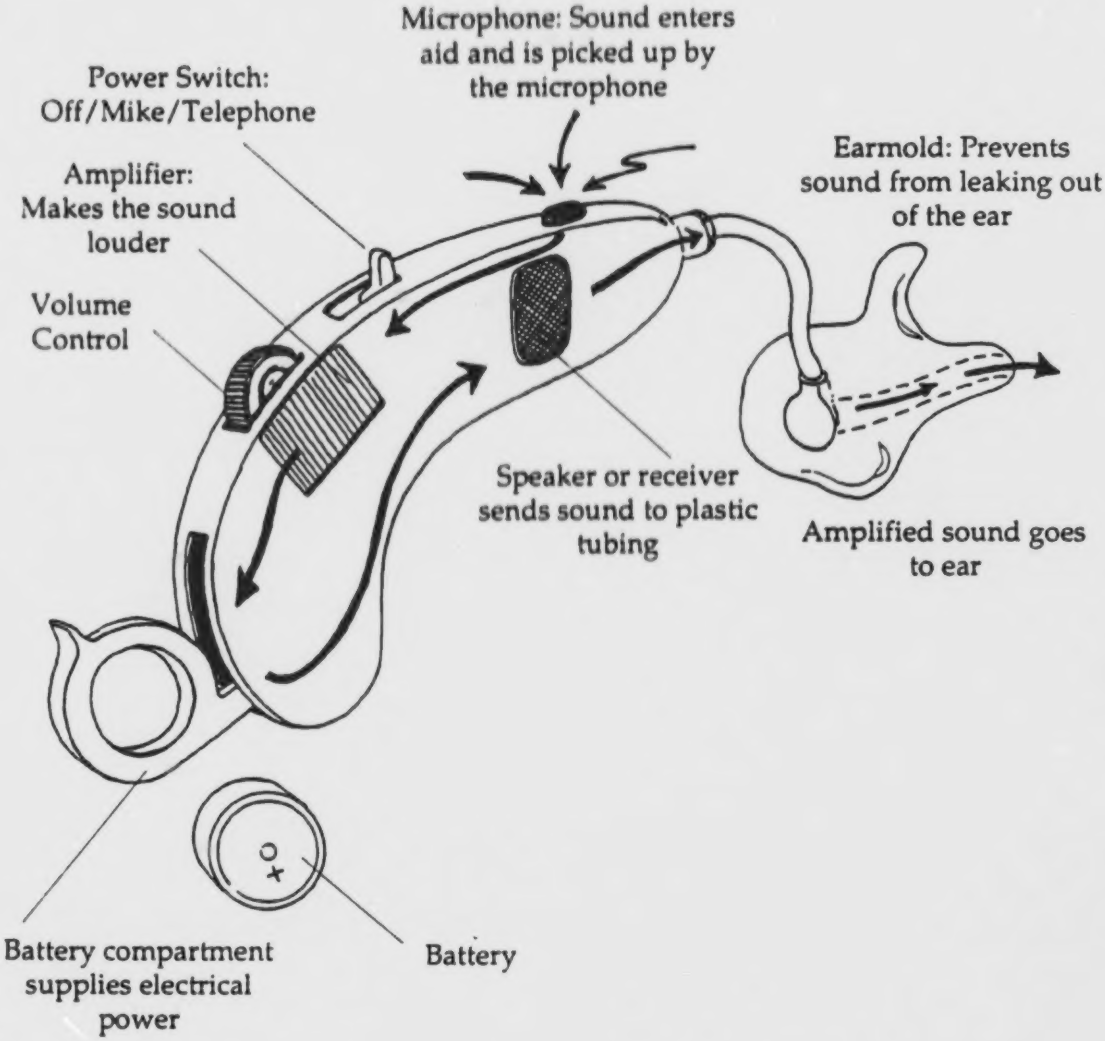
Body Aid


Volume Control On/Off Switch
Battery Door
Sound Inlet
Cord
Receiver Button
Earmold

Eyeglasses Aid


Battery Holder-On/Off Switch
Sound Inlet
Plastic Tubing
Earmold
Volume Control

OPERATION OF A HEARING AID


Microphone: Sound enters aid and is picked up by the microphone
Power Switch: Off/Mike/Telephone
Earmold: Prevents sound from leaking out of the ear
Amplifier: Makes the sound louder
Volume Control
Speaker or receiver sends sound to plastic tubing
Amplified sound goes to ear
Battery compartment supplies electrical power
Battery

COMMUNICATING WITH THE APHASIC CLIENT

Aphasia - Language difficulty, due to brain damage, which can affect listening, speaking, reading, and writing skills.

Comprehension

Simplify

1. Talk about only one idea at a time.
2. Use short sentences with simple, common words.
3. Use gestures, facial expressions, vocal inflections.

Allow Time

1. Pause between short sentences.
2. Slow down rate of speech and allow the client time to process information.

Orient Client

1. Discuss topics of interest in the client's life.
2. Orient client to people, place, and time by pointing out and discussing people and items in the environment.
3. Keep client aware of time of day via mealtimes, medications, and announcements of visitors and times they frequently come.

Confirm

Client may respond to gestures or sound of your voice without understanding you.

1. Ask client question.
2. Allow client to respond.
3. Ask client an opposite question; if client responds the same to both questions, you are not communicating.
4. Be sure you have client's attention.
5. Let client know there was a misunderstanding.
6. Speak more slowly.
7. Repeat and/or reword message.
8. Use gestures, pointing, and facial expressions. Do not speak more loudly if client did not understand you. Confusion increases with added noise and distractions, and when more than one person is talking.

Expression

Allow Time

Be patient and accepting of client's attempts to communicate.

Guess

1. Determine the subject by asking more specific questions.
2. Make statements about what you think the client means.

Alternative Communication

1. Communication board
2. Gestural system - devise own nonverbal methods - encourage pointing gestures, head nod. If you use gestures when communicating with aphasic clients, this may stimulate their use of gestures.

Verbal Communication

1. Ask questions requiring yes/no or one-word response.
2. With more verbal clients who have word-finding difficulties, encourage substitute ways of expressing meaning by asking questions like:
   "What do you use it for?"
   "Where is it?"
   "What does it look like?"
   "Why do you need it?"
3. When a client does convey what he/she wants, in a way other than verbal, say the word for him/her.

Respect

1. Speak to the client in an adult manner; she/he is usually an intelligent adult who is quite aware of her/his surroundings even though language function is impaired.
2. Include the client in the conversation; don't talk as though he/she is not there, is deaf, or is mentally retarded.

LESSON PLAN: 5

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

SCOPE OF UNIT:

This unit is about how to chart accurately on the medical record; how to communicate effectively; how to make accurate observations about the clients and what to do with the information; how to use a care plan; basic telephone techniques; and measurements used in the health care field.

INFORMATION TOPIC: II-5 OR DEMONSTRATION:

CARE PLAN
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Describe a care plan.
3. Identify how a care plan is developed.
4. Identify goals of care plan.
5. List factors that may cause the client to be unable to meet his/her needs.
6. List ways in which the health care assistant can contribute to the care plan.
7. List four ways in which the care plan is of assistance to the health care assistant.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Organizing Your Work
2. HO 2: Overall Plan of Care - Sample
3. HO 3: Nurse Assistant Notes/Observations
4. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Biological Variations, video (TF #9E), 18 min.

b. Understanding the Older Adult, 4 videos (TF #68), 30 min. each; and The Interview and Mental Health Status Evaluation booklet (TF #68B)

5. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 5 (Student Reference page 79) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 13.

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Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 4

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 2.

INTRODUCTION:

Many members of the health care team in a health care facility give some care to client. The care plan is a means of ensuring that each health care team member is aware of the long- and short-term goals for the client and how these goals are to be met.

LESSON PLAN: 5

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

OUTLINE:

I. Terms and Definitions (II-1)

- A. Approach - a way or ways to reach the goal
- B. Assessment - an appraisal of the whole person to establish a baseline and determine the client's potential and his need for help
- C. Data collection - the act of collecting as much information as possible
- D. Goal - the desired end result, what one hopes to accomplish
- E. Implementation - carrying out a plan of action
- F. Need - something essential or desirable that one is lacking or something one feels is lacking
- G. Problem - needs that a client cannot meet by himself/herself
- H. Care plan - an individual plan of care for each client
- I. Nursing process - a problem-solving technique that consists of six steps: 1) data collection, 2) assessment, 3) problem identification/diagnosis, 4) planning, set goals and approaches to reach the goals, 5) implementation, and 6) evaluation
- J. Licensed facility - a facility that has met the requirements of the Division of Aging for licensure
- K. Intermediate care facility - facility with a director that is an RN or LPN; if the director is an LPN, the facility must have an RN consultant a minimum of four hours per week; if a level II facility, an LPN or RN must also be on the day shift; LPN or RN must be on call 24 hours per day
- L. Skilled nursing facility - facility that has a licensed nurse on duty to provide or supervise care of clients in long-term care as prescribed by the physician; director of nursing is an RN; an RN is on duty during day shift; an LPN or RN is on duty evening or night shift; an RN must be on call when an LPN is on duty
- M. Residential care facility I - provides shelter and board and may include storage and distribution of medications

N. Residential care facility II - provides shelter and board; includes storage and distribution of medications, supervision of diet, and assistance with personal care; may include care during short-term illness and recuperation

O. Licensed bed - beds for private pay individuals in licensed facilities

P. Certified bed - beds in a skilled or intermediate care facility that are licensed for medicaid clients

Q. Medicaid - a program funded by the federal and state governments for individuals whose income are below a certain level; it pays for medical costs

R. Medicare - a federal program that assists with medical costs for individuals over the age of 65

II. Description of a Care Plan (HOs 1, 2 & 3)

A. The care plan is a plan of action for assisting the client to fulfill the basic human needs, his/her own special needs, and to successfully carry out the activities of daily living and help the client live at his/her fullest potential. **(II-2)**

B. Care plan is prepared for each client.

C. The care plan is a form of written communication.

D. Legally, there must be a written care plan for each client in a certified bed. For a licensed-only facility, there is no specific requirement for a care plan. All clients in an acute care facility must have a care plan.

E. It provides a means for planning, assessing, implementing, and evaluating individual client's care.

III. Development of a Care Plan **(II-3)**

A. During a care conference, care plan is developed with input from members of the nursing and medical staff, especially the nurse assistant, and other consultants (e.g., activity director, social worker, physical therapist, occupational therapist, dietitian) as needed.

B. In the long-term care facility, the client and family are invited to participate.

C. The client's needs and strengths are discussed.

D. Team members make suggestions for meeting these needs and building on the strengths.

E. From these suggestions, the charge nurse lists the long- and short-term goals for the client and how they are to be met.

F. The long- and short-term goals and how they are to be met are then transferred to a nursing care form. This form is usually kept on a card file at the nurses' station. (Follow facility policy.)

G. The plan is always discussed with the client and is part of his/her record.

IV. Goals of a Care Plan **(II-4)**

A. To empower the client

B. To assist the client in fulfilling his/her basic human needs of:

1. Maintaining adequate nutrition
2. Eliminating waste
3. Being active (mobile)
4. Getting sufficient rest
5. Communicating with others
6. Breathing efficiently
7. Carrying out proper hygiene
8. Satisfying spiritual needs
9. Receiving emotional support

C. To assist the client in carrying out the activities of daily living - activities of daily living are activities that every person performs each day in caring for himself/herself.

V. Factors Which May Cause the Client to be Unable to Meet His/Her Needs. **(II-5)**

A. Poorly fitting dentures, digestive disorders, lack of appetite

B. Urinary catheters, constipation

C. Respiratory disease

D. Needing a walker or cane, confined to a w/c, foot problems such as bunions

E. Speaking in a different language, memory loss, hearing or vision loss, stroke, confusion

F. Unable to attend religious services

G. Anxious, depressed

H. Poor sleeping patterns, takes frequent short naps, frequently up to go to the bathroom

I. Unable to reach his/her entire body to bathe

VI. How the Care Plan Helps the Health Care Assistant (II-6)

A. Gives specific instructions regarding care to be given

B. Provides information needed before giving care to the client

C. Provides guidelines for the health care team to ensure continuity of care

D. Assists in organizing and planning work

VII. Role of the Health Care Assistant in Relation to the Care Plan (II-7)

A. Contribute to and be aware of the care plan for each assigned client.

B. Know of any changes in the care plan.

C. Follow the care plan when giving care.

D. Observe and assess the client's response to care given.

E. Report the client's response to care given.

F. When assigned, document the client's response.

VIII. Summary and Conclusion

A. Terms and definitions

B. Description of a care plan

C. Development of a care plan

D. Goals of the care plan

E. Factors which affect the client not being able to meet his/her needs

F. How the care plan helps the health care assistant

G. Role of the health care assistant in relation to the care plan

The care plan is very important to the health care assistant when planning and administering care to assigned clients. Be sure you understand and follow the policies and procedures related to the care plan in the health care facility where you are employed. The next lesson is on observation and reporting.

LESSON PLAN: 5

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. What are the definitions of the terms used in this lesson?
2. What is care plan?
3. How is care plan developed?
4. What are the goals of care plan?
5. What factors would prevent a client from being able to meet his/her needs?
6. How is the care plan of assistance to the health care assistant?
7. How can the health care assistant contribute to the care plan?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show a care plan from your facility. What did it tell you about the client that you did not know?
2. How will you use what you just learned about this client as you care for him/her?
3. Discuss who contributes information to the care plan.
4. Review health care plans of clients.
5. Show audiovisuals.

ANSWERS TO EVALUATION ITEMS:

1. f
2. b
3. a
4. e
5. d
6. c
7. d
8. b
9. b

10. Any four of the following:
    a. Poorly fitting dentures, digestive disorders, lack of appetite
    b. Urinary catheters, constipation
    c. Respiratory disease
    d. Needing a walker or cane, confined to a wheelchair, foot problems such as bunions, etc.
    e. Speaking in a different language, memory loss, hearing or vision loss, stroke, confusion
    f. Unable to attend religious services
    g. Anxious, depressed
    h. Poor sleeping patterns, takes frequent short naps, frequently up to go to the bathroom
    i Unable to reach his/her entire body to bathe

11. Any three of the following:
    a. Contribute to and be aware of the care plan for each assigned client.
    b. Know of any changes in the care plan.
    c. Follow the care plan when giving care.
    d. Observe and assess the client's response to care given.
    e. Report the client's response to care given.
    f. When assigned, document the client's response.

12. a. Gives specific instructions regarding care to be given.
    b. Provides information needed before giving care to the client.
    c. Provides guidelines for the health care team to ensure continuity of care.
    d. Assists in organizing and planning work.

LESSON PLAN: 5

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

___	1.	Goal	a.	Something essential or desirable that one is lacking or something one feels is lacking
___	2.	Implementation	b.	Carrying out a plan of action
___	3.	Need	c.	The act of collecting as much information as possible
___	4.	Care plan	d.	Need that a client cannot meet by himself/herself
___	5.	Problem	e.	An individual plan of nursing care for each client
___	6.	Assessment	f.	The desired end result; what one hopes to accomplish

7. Care plan is described as _________. (Circle the letter of the best answer.)

   a. A plan of action for a few clients who have special problems
   b. A form of verbal communication
   c. A plan of action developed only by the client and family
   d. A plan of action for all clients to fulfill their basic human needs and activities of daily living

8. As a health care assistant, you know the care plan is developed _________. (Circle the letter of the best answer.)

   a. By only the physician and other medical staff
   b. By members of the nursing and medical staff and other consultants as needed
   c. By only the physician
   d. By only the client and his/her family

9. Goals of care plan are to __________. (Circle the letter of the best answer.)

    a. Allow the client's family to make all decisions concerning care given
    b. Assist the client in fulfilling basic human needs and activities of daily living
    c. Tell the physician and medical staff what the client's needs are
    d. Provide a plan that only the health care assistant will know what has to be done for the client

10. List four factors which affect the client not being able to meet his/her needs.

    a.

    b.

    c.

    d.

11. List three ways in which the health care assistant can contribute to the care plan.

    a.

    b.

    c.

12. List four ways in which the care plan assists the health care assistant.

    a.

    b.

    c.

    d.

ORGANIZING YOUR WORK

Steps that will assist the health care assistant to organize the daily client care

1. Review your assignment.
   Is it specific?
   Do you have any other questions?

2. Listen to the report from the previous shift.
   Have any of the clients' conditions changed?

3. Visit all of the clients assigned to you.
   Greet clients with a smile.
   Introduce yourself by name and let the clients know that you will be their caregiver.

4. Listen to the clients and be a detective.
   What do you see, hear, smell, and feel?
   Trust your intuition. Be AWARE of verbal and non-verbal behaviors.

5. Identify the client's needs.
   Does client need assistance to bathroom, fresh water, or change of position?

6. Budget your time wisely.
   Which tasks are the most urgent? (First things first.)

Example of a form that can be used when making rounds

Observation Form			
Client's Name:			
Date	Time	Observation	Client's Need
Health care assistant may share observations and incorporate into shift care.			

HO 2

OVERALL PLAN OF CARE - SAMPLE

Care Plan 109

Personal Care:

BATH
Bathe M.W. Sat.
Partial P.r.n.
Self
Tub
Shower
Assist

MOUTH CARE
Nurse ✓
Self
Dentures ✓
Special

HAIR CARE
Shampoo bed
When 1/11
Nurse ✓
Self
Beauty Shop

SKIN CARE
Decubiti
Turning q̄ 2h
6-8-10-2-4
Dry
Shave
When

HAND/FOOT CARE
Manicure 1/12
Pedicure 1/12
Clean Nails Daily ✓
Self
Footboard ✓

(chair scale)
Weight q̄ tues.
Height
T.P.R. daily
B.P. daily
I & O. to 2500 c.c.
C & A

Long Term Goal: To be independent in A.D.L. by July 15

Date	Needs: Problems or Strengths	Short Term Goals	Plan of Action	Service Responsible	Review Date and Signature	Goal Met YES	Goal Met NO	Analysis: Why Goal Not Made
1/12/93	Totally dependent in A.D.L.	will turn self In bed unaided by 2/10	Reposition q̄ 2h	Nursing				
			Teach how to assist	P.T.				
			R.O.M. x 10 t.i.d.					
		Will assist in feeding self by 1/24	Position sitting in chair for meals	Nursing Dietary				
			Provide adaptive aids Teach to use	O.T.				
	Incontinent - admitted with catheter.	Will remove catheter by. 1/17	Push fluids 2500 c.c. daily Clamp catheter 55 min. of every hour					

Diagnosis: CVA / Rt. hemiplegia

Next of Kin: John J. Doe 314-654-2310

Name: Doe, Mrs. Martha Jane

Doctor: Ari Stotle

Room: 101

Age: 73

Religion: Protestant

Admission Date: 1/10/93

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Special Procedures:

Foley Catheter
clamp 55 min., q̄ hour
open drainage 9 p.m.-7 a.m.
no irrigation unless
problems with drainage.

Medications:

Inderol	40 mg. q.i.d.	
Librium	5 mg. b.i.d.	
Lasix	40 mg. q̄.d., p.r.n. for edema	
Colace	capt h.s., p.r.n. for constipation	
Pyridium	tabt t.i.d. x 14 days	

Prosthesis:
Dentures: ✓
Full ✓
Partial
Upper
Lower
Glasses: ✓
Contacts:
Hearing Aid:
Artificial Arm:
Leg:
Eye:
Other:

P.T.
R.O.M. x 10 all extremities t.i.d. (by P.T. o.d., Nurse Assistant b.i.d. in room.)

O.T.
Teach to use adaptive eating utensil in G-chair located in Special Dining Room.

Speech/Audiology:
Therapy 3x week (Mon., Wed., Fri., @ 10:30 a.m.)
To Speech Therapist's office via w/c

Diet: 2 Gm Sodium Restricted
Feed: ✓
Assist:

Self-Help Devices: Weighted spoon with extended handle.

Breakfast	Med A.M.	Dinner	Med P.M.	Supper	H.S.

Dislikes/Allergies: Salads
Milk

Activities:
Group:

Individual Activities Director - read letter and hometown newspaper, provide environmental stimulation.

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NURSE ASSISTANT NOTES/OBSERVATIONS

Room number:	Activity:	Dentures:	Nap:
	Bath:	Glasses:	Turn:
Name:	B&B:	Hearing Aid:	Transfer:
	Oral Care:	Nail Care:	Shampoo:
Catheter & Peri Care:		Meals:	Walk Aid:
Active Range of Motion:		Passive Range of Motion:	
Short-term Goals:	Intake/FF: (amount) Output: (amount)	T: _______, _____ R: _______ P: _______ Loc. _______ Reg. or Irr. BP: _________ L or R, position _________	
Notes:			

Room number:	Activity:	Dentures:	Nap:
	Bath:	Glasses:	Turn:
Name:	B&B:	Hearing Aid:	Transfer:
	Oral Care:	Nail Care:	Shampoo:
Catheter & Peri Care:		Meals:	Walk Aid:
Active Range of Motion:		Passive Range of Motion:	
Short-term Goals:	Intake/FF: (amount) Output: (amount)	T: _______, _____ R: _______ P: _______ Loc. _______ Reg. or Irr. BP: _________ L or R, position _________	
Notes:			

LESSON PLAN: 6

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

SCOPE OF UNIT:

This unit is about how to chart accurately on the medical record; how to communicate effectively; how to make accurate observations about the clients and what to do with the information; how to use a care plan; basic telephone techniques; and measurements used in the health care field.

INFORMATION TOPIC: II-6 OR DEMONSTRATION:

OBSERVATION AND REPORTING
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List five methods of observation.
3. Identify changes in client's usual appearance and behavior that are to be reported.
4. Identify guidelines for reporting observations of status change in clients to charge personnel.
5. Describe the correct procedure for answering a client's call light.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Observations to Report to the Instructor/Staff Personnel
2. HO 2: Intervention Through Observation
3. Television and VCR
4. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Working with Older People, video (TF #46) 60 min.
    b. As the River Flows...Medications and the Elderly: Physiological Changes and Dosing, video (TF # 156), 15 min.

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 6 (Student Reference page 93) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapters 10, 19, 29.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 7, Section 3.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 4, Section 3.

INTRODUCTION:

Making useful observations gives the health care assistant satisfaction and a feeling of achievement; but more important than that, it can provide nurses and physicians with important information for proper care of the client. Observation techniques must be practiced each day and require the use of all of one's senses. Get in the habit of observing your client any time you are with him/her. Check your client from head to toe each day. It is a good idea to carry a pad of paper and pen in your pocket to record observations so you will not forget to report and document them.

LESSON PLAN: 6

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

OUTLINE:

I. Terms and Definitions (II-1)

- A. Abrasion - a scraping or rubbing off of the skin
- B. Afebrile - without fever
- C. Anterior - toward the front
- D. Constipation - difficult or infrequent movement of the bowels
- E. Constrict - get smaller
- F. Contusion - an injury that does not break the skin, caused by a blow to the body and characterized by swelling, discoloration, and pain
- G. Cyanotic - a bluish-gray color of the skin, lips, or nail beds due to lack of oxygen
- H. Dilate - to get larger
- I. Disorientation - state of mental confusion or loss of bearings (sense of time, place, or identity)
- J. Distention - state of being inflated, enlarged, or stretched out
- K. Dysphagia - difficulty swallowing
- L. Dyspnea - difficulty in breathing
- M. Edema - swelling due to an accumulation of watery fluid in the tissue
- N. Emesis - vomiting
- O. Febrile - feverish
- P. Feces - waste products of digested food discharged from the intestine (stool, BM)
- Q. Fever - elevation of body temperature above normal
- R. Flatus - gas

S. Flushed - reddened color of the skin

T. Incontinent - inability to control evacuation of one's bowels or bladder or both

U. Inflammation - reaction of tissue to injury of any kind

V. Jaundice - yellow discoloration of skin due to bile

W. Laceration - wound produced by cutting or tearing

X. Mucus - sticky substance secreted by mucous membranes mainly in the lungs, nose, and parts of the rectal and genital areas

Y. Pallor - paleness

Z. Posterior - towards the back

AA. Projectile vomiting - vomitus forcibly ejected without nausea

AB. Pus - thick yellowish secretion formed in certain kinds of inflammation

AC. Void - to pass urine

II. Five Methods of Observation - you have used your senses for observation all of your life but may have never realized it **(II-2)**

A. Seeing

1. Look and think about what you are seeing and what it means.

2. Observe for skin rash, reddened areas, edema, etc.

B. Hearing

1. Listen to a sound and try to understand what it means.

2. Listen for a cough or wheezing sound when the client breathes.

3. Some changes can be felt and described only by the client - pain, nausea, dizziness, a ringing in the ears, or headache. Listen for verbal signs from the client.

C. Smelling - smell the odor of a discharge or the client's breath

D. Touching

1. You can feel signs with your fingers.

2. You may note if the skin is hot or cold and wet or dry or if there are changes in the pulse rate.

E. Vital signs - a change can indicate many things; anything not within normal range may be significant and should be reported

III. Things to Observe (HOs 1 & 2) **(II-3)**

A. Activities of daily living (independent/dependent)

1. Dressing - untidy, unclean, or neat, clean

2. Grooming - untidy or neat

3. Walking

a. Gait steady or unsteady; shuffling

b. Difficulty getting up and out of bed

4. Eating and drinking

a. Good appetite or no appetite

b. Dislikes diet or tries some of each food

c. Amount eaten or type and amount not eaten

d. Dysphagia or difficulty swallowing

e. Thirsty or seldom drinks water

5. Elimination

a. How often does client void?

b. Note color, odor, amount, and clarity (clearness) of urine.

c. Is voiding hard to start or is there pain during urination?

d. Is the client incontinent of urine?

e. Is the catheter in place and draining properly?

f. How often does a client have a bowel movement?

g. Note color, odor, amount, and consistency (liquid, loose, hard) of stool.

h. Note blood, clumps of mucus, clay color, or if feces looks like black tar.

6. Sleeping

    a. Able to sleep or restless

    b. Sleeps more than normal, constantly asleep

    c. Lies still or tosses around

    d. Complains about not being able to sleep (compare with your observation)

B. Mental condition or mood (II-4)

1. Level of orientation--who, what, where

2. Talkative or not talkative

3. Talking sensibly or not making sense

4. Anxious and worried or very calm

5. Speaking rapidly or slowly

6. Cooperative or not cooperative

7. Client is irritable, depressed, hostile, combative

8. Delirium

    a. Continuous or intermittent; rambling of ideas or one persistent idea

    b. Coma or unconscious, failure to respond to verbal commands or stimuli

9. Crying - fretful, sharp, whining, or moaning; give reason if known

C. Position

1. Time of position change; what position client is put in

2. Able to move easily or requires assistance of two or three staff members

D. Skin

1. Color - pallor, flushed, cyanotic, jaundiced

2. Dry or moist

3. Warm (hot) or cool (cold)

   4. Edema - location, general or local, any color changes
   5. Reddened areas - location, open, size, drainage
   6. Rash, hives, itching, bruises, abrasions, lacerations

E. Eyes, ears, nose, and mouth
   1. Eyelids inflamed; watery eyes; bloodshot appearance or yellowish cast to the whites of the eyes
   2. Bothered by bright light; twitching
   3. Pupils - constricted or dilated; unequal or equal in size
   4. Eyes appear to be fixed; constant involuntary movement
   5. Ability to hear you
   6. Difficulty breathing through his/her nose
   7. Mucus discharge from the nose
   8. Mouth - lost or broken dentures, sores, tenderness, bleeding gums
   9. Complaint of a bad taste in the mouth; odor of breath - foul (halitosis), sweet or fruity, alcohol

F. Breathing
   1. Noises when he/she breathes; wheezing; moist sounding
   2. Dyspnea; difficult or labored breathing usually accompanied by pain
   3. Cough - productive (note amount, color, and consistency of sputum) or dry; tight hacking, painful

G. Abdomen
   1. Stomach puffy, distended, hard, rigid, tender
   2. Gassiness, belching, hiccups
   3. Nausea
   4. Emesis - self-induced; projectile; note color, consistency, and amount

H. Movements
   1. Shaking - tremor

    2. Jerky - spasm

    3. Limp

I. Pain

    1. Location

    2. Duration (How long has he/she had pain?)

    3. Description of pain - constant, comes and goes; sharp, dull; aching, knifelike

    4. If client has taken pain medication, has the medication relieved the pain?

J. Vital signs

    1. Temperature - febrile or afebrile

    2. Pulse - rhythm--regular or irregular; rate--too fast or too slow; force--strong or weak

    3. Respiration

        a. Rhythm - regular or irregular; rate-too fast or too slow; shallow

        b. Cheyne-Stokes - uneven rhythm and rate and periods of no breathing

        c. Noisy breathing - normal breathing cannot be heard

    4. Blood pressure - strong (easy to hear) or weak (difficult to hear)

K. Each client's unit

    1. Check that all equipment is working. Make sure there are no frayed electrical cords.

    2. Make sure the call signal is where the client can easily reach it.

    3. Articles on the bedside table must be within easy reach for the client.

L. Other

    1. Convulsions - time, duration, intermittent or continuous; mild or violent; generalized or limited to one part of the body

    2. Chills - time and duration, severity of chill; temperature at time chill is completed, temperature 30 minutes after chill is completed

3. Accidents or incidents - time, witnesses, observations of injury, and cause of suspected injury

4. Discharges - unusual body discharge; location and type (bloody, mucus, pus, or clear)

IV. Guidelines for Reporting Observations of Status Change **(II-5)**

A. Observe for the unusual, then report only what you observe. Be objective, do not make judgments or try to diagnose.

B. Note the time, the name of the client, location of any abnormal signs, location of client in facility, any symptoms the client mentions, and report to the charge nurse as soon as possible.

V. Answering the Client's Call Light **(II-6, 7)**

A. Go to the client at once, quietly, and in a friendly way.

B. Turn off the call signal, and address client by name.

C. Say, "Mr. Jones, what can I do for you?" Do whatever the client asks, but be sure it is correct and safe for this client.

D. When necessary, use emergency signal to get qualified personnel to assist you.

E. CAUTION: A young child or helpless adult may not be able to use the signal cord. Listen for calls for help; do frequent, routine checks.

F. It is important to respond to the call light quickly, as the client may have an emergency or simply seek reassurance that help is available if needed.

VI. Summary and Conclusion

A. Terms and definitions

B. Five methods of observation

C. Things to observe

D. Guidelines for reporting observations of status change

E. Answering the client's call light

Making observations is one of the most important functions of your job as a health care assistant. Always be alert for changes and abnormalities of the condition of each of your clients. Become familiar with the terminology that has been included in this lesson. The next lesson is on charting on medical records.

LESSON PLAN: 6

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. What are the definitions of the terms used in this lesson?
2. What methods might you use to observe the client?
3. What observations should you make about the way your client appears to you?
4. What observations should you make with regard to your client's behavior?
5. What guidelines should the health care assistant use for reporting observations?
6. How do you answer a client's call light?
7. Why is it important to respond quickly to a call light?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Write a short paragraph about another classmate or a client after observing him or her for a few minutes (use all observation methods, if applicable).
2. Show video.
3. Go to clinical area--observe edema, lung congestion, reddened areas, etc.
4. Play act giving an oral report.
5. Have students role play the following situations. One appropriate response has been included for each.

   a. Mrs. Smith yells at you as you enter her room, "Hurry up and get me dressed. What's wrong with you? Can't you see that I need to be helped first?" The tone of her voice is sharp and impatient. As you are assisting Mrs. Smith to the W/C you note a sweet, fruity odor on her breath; she has a skin tear that is oozing blood on her right forearm; and her face is flushed and very warm. What observations can you make?

      Observations: 1. The tone of the client's voice; 2. Sweet, fruity odor on her breath; 3. Skin tear that is oozing blood--right forearm; 4. Flushed and warm face. Report all of these things immediately to the charge nurse.

b. **You are in the dining room at noon. Mrs. Mabel Howell, a client, is sitting next to the client you are feeding. She keeps repeating "I'm so sick," she appears pale--all of a sudden she grabs her chest and starts crying out with pain. The CMT comes over and starts to check her vital signs and asks you to go get the nurse. What will you tell the nurse?**

Observations: Mrs. Mabel Howell is sitting in the dining room. She is pale and stated "I'm so sick." She grabbed her chest and started crying out loud. The CMT is checking her vital signs now.

ANSWERS TO EVALUATION ITEMS:

1. j
2. a
3. i
4. k
5. d
6. c
7. g
8. b
9. f
10. l
11. h
12. e
13. b
14. c
15. j
16. e
17. d
18. g
19. h
20. k
21. i
22. l
23. f
24. a
25. m

26. a. Location
    b. Duration
    c. Description of pain
    d. If the client has taken pain medication

27. a. Seeing
    b. Hearing
    c. Smelling
    d. Touching
    e. Vital signs

28. c
29. b
30. c

31. a. **May be an emergency**
    b. **Client seeks reassurance that we are there to care for him/her**

32. **Answer should include going to client at once, turning off call signal and use of emergency signal when necessary.**

LESSON PLAN: 6

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. What are the definitions of the terms used in this lesson?
2. What methods might you use to observe the client?
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4. What observations should you make with regard to your client's behavior?
5. What guidelines should the health care assistant use for reporting observations?
6. How do you answer a client's call light?
7. Why is it important to respond quickly to a call light?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Write a short paragraph about another classmate or a client after observing him or her for a few minutes (use all observation methods, if applicable).
2. Show video.
3. Go to clinical area--observe edema, lung congestion, reddened areas, etc.
4. Play act giving an oral report.
5. Have students role play the following situations. One appropriate response has been included for each.

    a. Mrs. Smith yells at you as you enter her room, "Hurry up and get me dressed. What's wrong with you? Can't you see that I need to be helped first?" The tone of her voice is sharp and impatient. As you are assisting Mrs. Smith to the W/C you note a sweet, fruity odor on her breath; she has a skin tear that is oozing blood on her right forearm; and her face is flushed and very warm. What observations can you make?

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Observations: Mrs. Mabel Howell is sitting in the dining room. She is pale and stated "I'm so sick." She grabbed her chest and started crying out loud. The CMT is checking her vital signs now.

ANSWERS TO EVALUATION ITEMS:

1. j
2. a
3. i
4. k
5. d
6. c
7. g
8. b
9. f
10. l
11. h
12. e
13. b
14. c
15. j
16. e
17. d
18. g
19. h
20. k
21. i
22. l
23. f
24. a
25. m

26. a. Location
    b. Duration
    c. Description of pain
    d. If the client has taken pain medication

27. a. Seeing
    b. Hearing
    c. Smelling
    d. Touching
    e. Vital signs

28. c
29. b
30. c

31. a. May be an emergency
    b. Client seeks reassurance that we are there to care for him/her

32. Answer should include going to client at once, turning off call signal and use of emergency signal when necessary.

OBSERVATIONS TO REPORT TO THE INSTRUCTOR/STAFF PERSONNEL

Observe closely and accurately, and report promptly:

1. All symptoms - noted by the client or observed but for which no complaint is voiced
2. Change in vital signs - temperature, pulse, respirations, and blood pressure
3. Change in personality - weak, depressed, apathetic, apprehensive, or hysterical
4. Change in skin color - sudden pallor, yellowish flushing, cyanosis, or blotching
5. Change in respiration - difficult breathing (dyspnea), rapid respirations, gasping, inability to breathe except when sitting or standing erect, or painful breathing
6. Breath - unpleasant, foul, sweet or fruity odor, or smell of alcohol
7. Cough - exhausting, harsh, tight, dry, hacking, painful or wheezing; if productive, report quantity, color (rusty, green, bloody), thick or mucoid
8. Dizziness - any loss of balance, complaint of dizziness, or faintness
9. Nausea or vomiting - self-induced by client, projectile (with force projection), color (bloody, coffee ground color, greenish), and consistency (liquid or undigested food)
10. Convulsions - time, duration, intermittent or continuous, mild or violent, and generalized or limited to one part of the body
11. Delirium - continuous or intermittent, rambling of ideas or one persistent idea, coma or unconsciousness, failure to respond
12. Chills - time and duration, severity of chill (violent or shivering), temperature at time chill is completed, and temperature 30 minutes after chill is completed
13. Crying - fretful, sharp, whining, or moaning; give reason if known
14. Discharges - unusual body discharge, location, and type (bloody, mucus, pus, or clear)
15. Swelling (edema) - generalized or local (as legs and feet), color change accompanying swelling
16. Skin conditions - dryness, scales, rash, hives, blotching, boils, itching, reddened areas, bruises, abrasions, bedsores, open raw areas
17. Abdomen - distended, hard, rigid, painful, tender

18. Eyes - bloodshot, dull, yellowish color, anxious, inflamed, watery and tearing, sensitive to light, twitching, pupils contracted, dilated, or unequal, constant involuntary movement of eyeballs, fixed look

19. Appetite - loss of appetite, failure to eat a meal (may be diabetic), eating of additional foods while on restricted diet, any difficulty the client may have swallowing, chewing or feeding himself/herself

20. Accidents or incidents - time, names of witnesses, observations of injury, and cause or suspected cause of bruises and abrasions

21. Sleep - moaning, restless, inability to sleep, short interval sleeping

22. Oral hygiene - lost or broken dentures or bridgework, mouth sores, tenderness, bleeding gums

23. Physical activities - failure of ambulatory client to get out of bed or refusal to walk or exercise

24. Bowel - diarrhea, stool of unusual color (clay or black with blood), hard-formed stool, failure to defecate, any variation from normal established bowel habits

25. Urine - unusual odor, color, cloudy, or bloody; change in output or failure to void, catheter drainage system not open or draining an inadequate amount of urine

26. Bath - failure to give bath or refusal of client to receive bath or other routine nursing service for which you are responsible

27. Personality change - irritable, depressed, anxious, hostile, combative, inappropriate laughter or crying, withdrawn

INTERVENTION THROUGH OBSERVATION

1. When the client attempts to play on your feelings and turns the conversation back to you, remain objective and gently remind him/her that you were talking about him/her.

2. When the client feels a need to do something "right" and/or is slow and methodical, you can help by rearranging the schedule to allow more time for projects and to cut down on interruptions.

3. When the client is distrustful, speak clearly to reduce misunderstandings and create a feeling of acceptance.

4. When the client seems lonely, demanding or picky, you can help by arranging for someone to spend time with that person.

5. When a client is domineering, inappropriately loving, or changes emotions rapidly, remain calm, unhurried, and avoid arguments with him/her.

6. When a client is uncertain and can't bear criticism, assist him/her to verbalize his/her feelings.

7. When the client is skeptical, resentful, and/or sarcastic, remain calm, unhurried, and self-assured.

LESSON PLAN: 7

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

SCOPE OF UNIT:

This unit is about how to chart accurately on the medical record; how to communicate effectively; how to make accurate observations about the clients and what to do with the information; how to use a care plan; basic telephone techniques; and measurements used in the health care field.

INFORMATION TOPIC: II-7 OR DEMONSTRATION:

CHARTING ON MEDICAL RECORDS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms to correct definitions.
2. Describe the three elements necessary to formulate words.
3. Match common abbreviations and symbols with correct terms.
4. Chart observations using basic guidelines.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Glossary of Word Elements
2. HO 2: Keys to Good Charting
3. HO 3: Check Charting Form
4. Pen
5. Charting Paper
6. Blackboard
7. Dictionary
8. Television and VCR

9. The Client Record: A Tool for Optimizing Quality Care and Malpractice Prevention, video (TF #119), 59 min., available from the Missouri Division of Aging Film Library

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 7 (Student Reference page 109) prior to class and be prepared to discuss the information presented.

REFERENCES:

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Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 11.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 7, Section 3.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 4, Section 3.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 6.

INTRODUCTION:

In health care facilities there is a need for accurate descriptions of the care given to clients and the conditions that exist throughout a client's stay. The progress notes must communicate clearly and efficiently with government agencies, health care professionals, and the consumer. We will discuss how to record effective, accurate descriptions of care given and observations made of your assigned client. How much you will need to record depends upon the facility's policy where you are employed. Always check the health care facility policy manual for approved abbreviations at that facility.

LESSON PLAN: 7

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

OUTLINE:

I. Terms and Definitions **(II-1)**

   A. Ambulatory - able to walk

   B. Urinary catheter - a sterile tube inserted into the bladder to drain urine

   C. Chart - the client's record

   D. Kardex - a card file with a summary of information found in the client's chart

   E. Nursing care plan - a written guide that gives directions about the nursing care a client must receive

   F. Objective data - information and symptoms that the health care assistant can see, hear, feel, and smell

   G. Observation - collection of information about the client by seeing, hearing, touching, and smelling

   H. Recording - charting of our observations on the client's charts

   I. Reporting - verbal report of care and observations to another nurse

   J. Signs - objective data

   K. Subjective data - signs and symptoms that cannot be observed by seeing, hearing, touching, and smelling; that which is reported by the client

II. Word Elements (HO 1)

   A. Root - body or main part of the word

   B. Prefix - word element added to the beginning of a root which changes or adds to the meaning of a root

   C. Suffix - word element added at the end of a root which changes or adds to the meaning of a root

   D. Formulation of words

      1. Prefix with root

2. Root with suffix

3. Root with root

4. Prefix with suffix

III. Abbreviations and Symbols **(II-2)**

A. Activities of daily living (ADL)

1. ad lib - as desired

2. amb. - ambulatory

3. BM - bowel movement

4. BRP - bathroom privileges

5. BSC - bedside commode

6. cath. - catheter

7. G/C - geri-chair

8. H.O.B. - head of bed

9. R.O. - reality orientation

10. R.O.M. or ROM - range of motion

11. SOB - shortness of breath

12. W/C or w/c - wheelchair

B. Food and fluids

1. ac or a.c. - before meals

2. amt. - amount

3. cc - cubic centimeter

4. FF - frequent fluids

5. H_2O - water

6. I & O - intake and output

7. IV - intravenously

8. liq. - liquid
9. NPO - nothing by mouth
10. pc or p.c. - after meals
11. PO or p.o. - by mouth
12. s̄s̄ - one half

C. Vital signs

1. VS pr v.s. - vital signs
2. BP - blood pressure
3. ht - height
4. TPR - temperature, pulse, respiration
5. wt - weight

D. Time and frequency

1. a.m. or A.M. - morning
2. bid or b.i.d. - twice a day
3. hr - hour
4. hs - hour of sleep; bedtime
5. od - daily
6. p.m. or P.M. - afternoon
7. prn - whenever necessary
8. q - every
9. qid - four times a day
10. tid or t.i.d. - three times a day
11. qd - every day

E. Miscellaneous

1. ā - before

2. B&B - bowel and bladder
3. c̄ - with
4. c/o or C/O - complains of
5. O_2 - oxygen
6. p̄ - after
7. s̄ - without
8. Sol - solution
9. OS - left eye
10. OD - right eye
11. OU - both eyes

IV. Charting (II-3)

A. Purpose

1. To communicate with other members of the health care team
    a. Physician's orders are written based on the needs of the client.
    b. Care plan (needs are identified)
    c. Progress notes
2. Legal document describing the delivery of care to meet needs of the client
3. Legal document to provide evidence to regulatory agencies that care has been provided as ordered and requirements for licensure and certification are met
4. To document for insurance purposes and/or legal actions

B. Charting responsibilities

1. Monthly summary done by licensed or charge personnel in long-term care facilities
2. Every shift done by licensed personnel in acute care facilities
3. Daily care routines (bathing, B&B, turning, etc.) charted by personnel completing task

C. Basic rules (HO 2)

1. Notes must be precise and exact. Report and record in an objective way, not subjective.

   Example: Subjective - Mrs. Smith fell on the floor.

   Objective - Found Mrs. Smith seated on floor beside bed.

2. Do not skip lines.

3. Use only approved abbreviations (see facility's policy).

4. Never erase. If you make a mistake, draw a line through the error; write "error"; and write your initials by it for identification. Use a ball-point ink pen, which is color-coded by the facility.

5. Use simple, correct terminology. Use correct grammar, spelling, and punctuation (refer to a dictionary).

6. Use direct quotes when describing an emotional statement.

   Example: Mrs. Jones stated, "I am so depressed today."

7. Indicate number of times an event occurs during a shift, day, week, etc.

8. Make follow-up notations of results of actions relative to the care plan.

9. If facility's policy allows, read notations by other personnel.

10. Record client's reactions to family and visitors.

11. Never chart a procedure before it has been performed.

12. All charting is done in ink with a ball-point pen. Do not use felt-tipped pens.

13. Always record date and time.

14. Second-hand information which is reported should be recorded as such (information that was told to you by the client's roommate for example). Do not chart it as your own first-hand observation; describe situation and name of individual who you received information from.

15. Always sign your name with first initial, last name, and job title, - M. Smith, CNA.

16. Printing or writing must be legible.

D. Variations in charting

1. Check chart (HO 3)

a. Check the appropriate square

b. Check the appropriate description of action

2. Narrative nurse's notes (nurse's progress notes) written out in sentence form; should cover the following information:

a. Mobility and balance

b. Diet and eating habits

c. Bathing, dressing, and grooming

d. Elimination

e. Speech, hearing, and sight

f. Behavior and mental condition

g. Restorative nursing procedures

h. Dentition (condition of teeth) and oral hygiene

i. Comfort measures

j. Spiritual needs

k. Sleeping patterns

l. Any other problems identified

V. Summary and Conclusion

A. Terms and definitions

B. Word elements

C. Abbreviations and symbols

D. Charting

Accurate documentation of the care given to a client is important to prove that the expected care was given. It should be brief but descriptive. Decisions affecting care can be made on the basis of what is recorded on the chart. Always think before you write. The next lesson is on basic telephone techniques.

LESSON PLAN: 7

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. **What are the definitions of terms presented in this lesson?**

2. **What are the three elements necessary for forming words?**

3. **What do the following abbreviations and symbols mean: pc, qid, TPR, R.O.M., ā, cc, amb, BM, R.O., q, O_2, tid, hs, B&B, c̄, ad lib, NPO, BRP, HOB, and SOB?**

4. **What are the basic rules of charting?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Prepare flash cards for "Abbreviation Bee."**

2. **Divide class into two groups for "Abbreviation Bee."**

3. **Fill out check charting form (HO 3 or facility's form) using information given by the instructor.**

4. **Discuss with the class the importance of not erasing while charting.**

5. **Discuss keys to good charting (HO 2).**

6. **Show audiovisuals.**

7. **Review facility's forms and guidelines for completing forms.**

ANSWERS TO EVALUATION ITEMS:

1. e
2. f
3. b
4. g
5. a
6. c
7. c
8. e
9. g
10. f
11. a

12. b
13. a
14. g
15. d
16. a
17. b
18. c
19. f
20. c
21. f
22. g
23. e
24. a
25. d
26. d
27. a
28. g
29. b
30. f
31. c
32. Weight before breakfast without shoes
33. Nothing by mouth at bedtime for blood test in the morning
34. Bed rest with bathroom privileges; head of bed may be raised because of shortness of breath
35. Apply lotion twice a day whenever necessary for itching
36. d
37. c
38. d

39.

Nurse's Notes			
LAST NAME FIRST NAME *Chase, Mrs. Polly*	ATTENDING PHYSICIAN: *Hypo Crates, M.D.*	ROOM NO.: *100-1*	HOSPITAL NO.: *77-334522*
DATE:	**Notes should be signed by Physician.**		
11-23-93	*7-11 a.m. ate 90% breakfast. Partial bath given. Out of bed while bed*		
	made. Seen by Dr. Hypo Crates. c/o headache to x-ray by W/C------------		
	---S. Jones, CNA		

LESSON PLAN: 7

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

EVALUATION ITEMS:

Match the following terms in Column I with the correct abbreviations and symbols in Column II.

		Column I		Column II
___	1.	Nursing care plan	a.	Able to walk
___	2.	Chart	b.	Signs and symptoms which are reported by the client
___	3.	Subjective data	c.	A sterile tube inserted into the bladder to drain urine
___	4.	Objective data	d.	A card file with a summary of information about the client
___	5.	Ambulatory	e.	A written guide that gives directions about nursing care which the client is to receive
___	6.	Urinary catheter	f.	The client's record
			g.	Information and symptoms that can be seen, heard, felt, and smelled

Match the following terms in Column I with the correct abbreviations and symbols in Column II.

		Column I		Column II
___	7.	Ambulatory	a.	Cath
___	8.	Head of bed	b.	W/C
___	9.	Bathroom privileges	c.	amb.
___	10.	Range of motion	d.	SOB
___	11.	Catheter	e.	H.O.B.
___	12.	Wheelchair	f.	R.O.M.
			g.	BRP

13. Elements necessary for forming words are: (Circle the letter of the best answer.)

a. Prefix, suffix, and root
b. Objective data
c. Subjective data
d. Sound, spelling, and use

Match the following terms in Column I with the correct abbreviations and symbols in Column II.

		Column I		Column II
____	14.	Bowel movement	a.	ac
____	15.	Amount	b.	H_2O
____	16.	Before meals	c.	I & O
____	17.	Water	d.	amt
____	18.	Intake and output	e.	FF
____	19.	Nothing by mouth	f.	NPO
			g.	BM

Match the following terms in Column I with the correct abbreviations and symbols in Column II.

		Column I		Column II
____	20.	After meals	a.	BP
____	21.	By mouth	b.	od
____	22.	One half	c.	pc
____	23.	Temperature, pulse, respirations	d.	bid
____	24.	Blood pressure	e.	TPR
____	25.	Twice a day	f.	PO
			g.	$\overline{ss}$

Match the following terms in Column I with the correct abbreviations and symbols in Column II.

Column I	Column II
____ 26. Hour of sleep; bedtime	a. od
____ 27. Once daily	b. q
____ 28. Whenever necessary	c. s̄
____ 29. Every	d. hs
____ 30. Four times a day	e. tid
____ 31. Without	f. qid
	g. prn

On the lines provided, write out what each of the following means:

32. Wt ā breakfast s̄ shoes.________________________________

33. NPO at hs for blood test in a.m.________________________________

34. Bed rest c̄ BRP, H.O.B. up for SOB________________________________

35. Apply lotion bid prn itching________________________________

36. Which of the following is the correct way for this nurse assistant to sign her name? (Circle the letter of the best answer.)

    a. Susan Metz
    b. Susan Metz, CNA
    c. S. Metz
    d. S. Metz, CNA

37. You have made an error in charting on a client's chart. Which one of the following examples below is the procedure for correcting it? (Circle the letter of the best answer.)

    a. Draw one line through it.
    b. Mark several lines through it.
    c. Draw one line through it, write the word "error," and place your initials by it.
    d. Erase the error.

38. Which of the following would not be in complete nursing notes? (Circle the letter of the best answer.)

- a. Notes must be precise and accurate.
- b. Date each notation accurately.
- c. Documentation should be related to the span of a shift.
- d. Exact hour and minutes is used to record all things.

39. Read the following situation. On the nurse's notes form below, chart according to basic guidelines.

Mrs. Chase was fed breakfast at 7:00 a.m. and ate most of it. She was given a partial bath. She sat in a chair while the aide made her bed. Dr. Hypo Crates made rounds at 10:30. Mrs. Chase went to x-ray in a wheelchair at 11:00 a.m. She complained of a headache prior to going to x-ray.

<table>
<tr><th colspan="6">Nurse's Notes</th></tr>
<tr><td>LAST NAME</td><td>FIRST NAME</td><td>ATTENDING PHYSICIAN:</td><td>ROOM NO.:</td><td colspan="2">HOSPITAL NO.:</td></tr>
<tr><td>DATE:</td><td colspan="5">Notes should be signed by Physician.</td></tr>
<tr><td></td><td colspan="5"></td></tr>
<tr><td></td><td colspan="5"></td></tr>
<tr><td></td><td colspan="5"></td></tr>
<tr><td></td><td colspan="5"></td></tr>
<tr><td></td><td colspan="5"></td></tr>
</table>

GLOSSARY OF WORD ELEMENTS

Word Element	Refers to or Means
a-, an-	without, lack of, absent, deficient
ab-, abs-	from, away
ad-	near, toward
adeno	gland
alb	white
-algia, -algesia	pain
ambi-	both
angio	vessel (blood or lymph)
ante-	before
anti-	against
arterio	artery
arthro	joint
-asthenia	weakness
auto-	self
bi-	two, twice
brady-	slow
broncho	bronchus
cardio	heart
-cele	tumor, swelling, hernia, sac
-centesis	puncture
cephalo	head
chole	gall

Word Element	Refers to or Means
cholecysto	gallbaldder
chondro	cartilage
cide	kill
circum-	around
-cise	cut
colo	colon
colpo	vagina
contra-	against
costo	rib
cranio	skull
cyano	blue
cysto	urinary bladder
cyto	cell
dermo, dermato	skin
di-	two
dys-	painful, difficult, disordered
ectomy	surgical removal
-emesis	vomiting
-emia	blood
encephalo	brain
endo-	within, inner, on the inside
entero	intestine
epi-	above, over
erythro	red

Word Element	Refers to or Means
-esthesia	sensation
ex-	out
gastro	stomach
-gene, -genic	production, origin
gluco, glyco	sugar, sweet
-gram	record
-graph	machine
-graphy	practice, progress
gyne	woman
hema, hemo	blood
hemi-	half
hepa, hepato	liver
histo	tissue
hydro-	water
hyper-	over, above, increased, excessive
hypo-	under, beneath, decreased
hyster	uterus
inter-	between
intra-	within
-itis	inflammation of
laparo	abdomen
-lepsy	seizure, convulse
leuko	white
lipo	fat

Word Element	Refers to or Means
lith	stone, calculus
-lysis	loosen, dissolve
mal-	bad, poor, disordered
-mania	insanity
mast	breast
mega-	large
meso-	middle
-meter	measure
micro-	small
mono-	single, one
muco	mucous membrane
myelo	spinal cord, bone marrow
myo	muscle
narco	sleep
naso	nose
necro	death
neo-	new
nephro	kidney
neuro	nerve
non-	no, not
oculo	eye
-ology	study of
-oma	tumor
oophor	ovary

Word Element	**Refers to or Means**
ophthalmo	eye
orchi	testicle
-orrhaphy	to repair a defect
ortho-	straight
-oscopy	look into, see
osis	condition of
osteo	bone
-ostomy	surgical opening
oto	ear
otomy	incision, surgical cutting
para-	alongside of
path	disease
ped (latin)	foot
ped (greek)	child
-penia	too few
peri-	around, covering
-pexy	to sew up in position
pharyngo	throat
phlebo	vein
-phobia	fear, dread
-plasty	operative revision
plegia	paralysis
-pnea	breathing
pneumo	air, lungs

Word Element	Refers to or Means
poly-	much, many
post	after
pre-	before
procto	rectum
-ptosis	falling
pyelo	pelvis of kidney
pyo	pus
pyro	heat, temperature
renal	kidney
retro-	behind, backward
-rhage	hemorrhage, flow
-rhea	flow
rhino	nose
salpingo	oviduct
semi-	half
septic	poison, infection
stomato	mouth
sub-	under
super	above
-therapy	treatment
-thermy	heat
thoraco	chest
thrombo	clot
thyro	thyroid gland

HO 1 cont.

Word Element	Refers to or Means
trans-	across
-uria, -uric	condition of, presence in urine
uro	urine
uni	one
vaso	blood vessel

HO 2

KEYS TO GOOD CHARTING

I. Describe what you see:

A. Activity of the client, including activities of daily living (dressing, bathing, feeding, personal hygiene, ambulation, continence)

1. Does the client need assistance? How much assistance? What can the client do?

2. Can the client tolerate activity? Does he/she become fatigued? Is the client short of breath?

3. What is the client's reaction to activity? Is the client uninterested, disgusted, etc.?

B. Diet and eating habits

1. How much food was eaten, 100%, 75%, 50%, 25%, none?

2. If less than 50% of food was eaten, list what was eaten and report to charge nurse.

3. If the client is a diabetic, chart what was eaten and report to charge nurse.

4. Chart food habits: likes sweets, eats from other trays, never eats vegetables, etc.

C. Mobility and balance

1. How is the client's position in bed, ambulating, and in chair?

2. Does the client use a cane or walker?

3. Describe gait and posture.

4. Does the client have contractures?

D. Skin condition

1. Is there any change from the normal skin condition: breaks, drainage, scratches, bruises, discolored area, or unusually dry?

2. Chart location, size, and color of anything unusual.

E. Discharge or drainage from any part of the body - Chart color, odor, consistency, and amount of drainage.

II. Describe what you hear:

  A. Speech

    1. Does the client have difficulty speaking: mumbles, slurs words, repeats the same words over and over, etc.?

    2. Does the client talk to family members in the same manner as the staff?

  B. Chart and report any unusual conversations.

    1. State exactly what the client said.

    2. If the client states that he/she has pain, chart how and when it occurred, where the pain is located, if it is a dull or sharp pain, and how long the client has had the pain.

  C. Note any unusual sounds: gurgling sounds in the throat, wheezing, and coughing.

III. Describe what you smell:

  A. Poor hygiene odors

  B. Fruity

  C. Ammonia-like smell

  D. Foul

  E. Sour

  F. Bad mouth odors

IV. Describe what you touch:

  A. Use your hands to check for any abnormal areas: smooth, enlarged, swollen, tender, thin, flat, distended, and hard.

  B. Is the client's skin cold, clammy, hot, or dry?

  C. Does the client react to touch as painful or as having no sensation?

CHECK CHARTING FORM

	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Appetite Breakfast %	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Lunch%	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bath or Shower	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Shampoo	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Shaved	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Oral Hygiene	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Skin Care	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nail Care	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Out of Bed	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Repositioned Q 2 Hrs.	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ambulated	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Siderails Up	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Restraints	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bowel Movement	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Fresh Water	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Initials 7-3 Shift	7-3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Appetite Supper %	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bath or Shower	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Out of Bed	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Shampoo	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Shaved	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Oral Hygiene	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Dentures Removed	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Skin Care/Back Rub	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Repositioned Q 2 Hrs.	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nail Care	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
P.M. Care	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
P.M. Nourishment	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ambulated	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Siderails Up	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Restraints Up	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bowel Movement	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Fresh Water	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Initials 3-11 Shift	3-11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bath	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Oral Hygiene	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Skin Care	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Repositioned Q 2 Hrs.	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Siderails Up	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Restraints	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bowel Movement	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Early A.M. Care	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Fresh Water	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Initials 11-7 Shift	11-7	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Appetite-Intake Code		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1-25% 3-75% 5-Refused		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2-50% 4-100%		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6-a few bites		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Physician

Allergies

Page No.

PATIENT

Room/Bed

Admissions No./Date

Sex

Date of Birth

Current Mo/Yr

BEST COPY AVAILABLE

LESSON PLAN: 8

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

SCOPE OF UNIT:

This unit is about how to chart accurately on the medical record; how to communicate effectively; how to make accurate observations about the clients and what to do with the information; how to use a care plan; basic telephone techniques; and measurements used in the health care field.

INFORMATION TOPIC: II-8 OR DEMONSTRATION:

BASIC TELEPHONE TECHNIQUES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List two criteria for answering incoming telephone calls.
2. List three steps in taking a phone message.
3. Identify the proper method of terminating a telephone conversation.
4. Identify effective telephone techniques.
5. Identify ineffective telephone techniques.
6. Identify tips in using a fax machine.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Telephone Techniques for the Health Professional
2. HO 2: Using Proper Telephone Techniques
3. HO 3: Using Proper Communications in an Emergency

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 8 (Student Reference page 133) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Hroneck, Dennis. Radiology Aide. Columbia: Instructional Materials Laboratory, University of Missouri-Columbia, 1987.

INTRODUCTION:

A person who is trained in proper use of the telephone can have a positive effect on building a professional atmosphere in the work place. The telephone conversation may be the only contact with the caller. Over the telephone, we do not have the advantage that we have in person when we are able to smile, use friendly gestures, and offer a warm handshake. On the phone, we must make up the difference with our voice and how well we come across to the caller. Remember, the person calling cannot see you and can only judge you and your place of employment through the all-important telephone conversation.

LESSON PLAN: 8

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

OUTLINE:

I. Criteria for Answering Telephone Calls (HO 1) **(II-1)**

A. Answer the phone on the first or second ring, if possible.

B. Identify the department or office by name.

C. Identify yourself by your first and last name and title.

D. Follow up with an appropriate phrase like "How may I help you?"

E. Find a pencil and piece of paper as you are starting the conversation and introducing yourself. "This is the ____ department; ____ speaking, may I help you?" By this time, you should have located a note pad and pencil or pen.

F. Display courtesy.

1. Use a natural and sincere manner of speaking.

2. Use a friendly tone of voice.

3. Develop the attitude of wanting to help other people. This positive attitude will come across on the phone.

4. Do not use standard phrases like, "Have a nice day," over and over again for every caller. Say something original that is appropriate to the person calling.

II. Taking a Telephone Message **(II-2)**

A. Determine the purpose of the call by listening to the caller and asking questions for clarification.

B. Always obtain the caller's name and phone number if he/she is leaving a message or making an appointment.

C. Repeat the information contained in the message back to the caller to make sure it is accurate.

III. Termination of Telephone Calls **(II-3)**

A. End the call in a sincere and agreeable manner.

B. Let the caller know that you were glad to be of service.

C. Try to allow the caller to hang up first.

IV. Effective Telephone Techniques (II-4)

A. Answer promptly.

B. Be prepared to take notes.

C. Repeat the caller's name frequently.

D. Space outgoing calls to allow incoming calls to come through.

E. If you must put someone on hold, take the name and number of the second caller and return to the first caller, apologizing for the delay.

F. If it is necessary to leave the phone, tell the caller how long you will be gone. Upon returning, greet the caller by name again and apologize for any unavoidable delay.

G. Speak distinctly and unhurriedly.

V. Ineffective Telephone Techniques (II-5)

A. Do not just say "Hello." State your department name and then your name and title followed by a statement like "May I help you?"

B. Do not say "Hold on for just a second." Say, "I will need to put you on hold for a minute or two Mr./Mrs./Ms ____. I will be right back."

C. Never provide client information to callers, even if they say they are representing the client. The only exception to this is if you know the person to whom you are speaking, and he or she is privileged to have the information (i.e., the client's doctor or doctor's nurse calls and wants an oral report).

D. Never contradict or argue with a caller.

E. Do not ever say no to an emergency, even though the caller may think it is an emergency and you may not think so. Meet the caller's needs.

F. Avoid losing your poise by becoming angry.

G. Do not discuss fees or charges over the phone, unless authorized to do so.

H. Do not say "The doctor is busy." Say, "The doctor is with a client and cannot come to the phone at this time. Is there anything that I may be able to do to help you?"

I. Never hang up on someone out of anger or frustration.

J. Avoid using slang words and phrases and giving casual responses.

   1. "Okay." Instead say, "Yes, that is alright," or "Yes, I understand."
   2. "Yeah." Instead say, "Yes."
   3. "Ya know?" Instead say, "Do you know?" or "Do you understand?"

VI. Tips in Using a Fax Machine **(II-6)**

NOTE: The term "fax" is a shortened version of the word "fascimile." A fax machine uses the telephone lines to send an exact duplication of printed words or graphics to another fax machine.

A. Read and follow fax machine operating instructions.

B. Handle all fax transmittals (what is sent or received through the fax machine) as confidential information.

C. Do not leave incoming and outgoing transmittals in the machine.

D. Send fax transmittals promptly.

E. Do not send personal materials through the fax machine unless the facility allows.

VII. Summary and Conclusion

A. Criteria for answering telephone calls

B. Taking a telephone message

C. Termination of telephone calls

D. Effective telephone techniques

E. Ineffective telephone techniques

F. Tips of using a fax machine.

The next unit is on safety.

LESSON PLAN: 8

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. How many criteria for answering the phone can you recall?
2. What are the three steps of taking a phone message?
3. What is the proper method for terminating a telephone conversation?
4. What is the most effective way to answer a telephone?
5. What are seven ineffective telephone techniques?
6. What are tips for using a fax machine?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Using two phones, role-play the following: (You may wish to tape record the role-plays so that students can listen to them later.)
    a. An irritated caller wants to talk to the doctor and does not really want to be put off.
    b. An attorney or insurance agent has called and is asking about the client's diagnostic report and how many procedures were done.
    c. A client calls asking you to recommend the best doctor to go to for a particular problem.
    d. A person calls and wants to tell you at length about her/his illness and the many exams that she/he has had, and will be having, and, and, and, and, etc.
    e. Someone calls asking for the cost of a procedure.
2. See if the class can come up with additional slang words or phrases to be avoided when processing a telephone call. Try to determine the correct, professional version of the same thing.
3. Practice answering the telephone, and see who sounds the most professional and positive. Students will be able to hear different styles and perhaps get the opinion of other students in class about how they sound on the phone and the effectiveness of the techniques that they use.

4. Have a class discussion on why it is important to smile and exhibit a positive and professional attitude just before answering the phone, no matter what is happening at the time.

5. Have the class discuss some of the irritating things that people in businesses have done when they spoke to them for business purposes.

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:

   a. Answer the phone on the first or second ring, if possible.
   b. Identify the department or office by name.
   c. Identify yourself by your first and last name, and title.
   d. Follow up with an appropriate phrase like "How may I help you?"
   e. Find a pencil and piece of paper as you are starting the conversation and introducing yourself. "This is the ____ department; _____ speaking, may I help you?" By this time, you should have located a note pad and pencil or pen.
   f. Display courtesy.
      1. Use a natural and sincere manner of speaking.
      2. Use a friendly tone of voice.
      3. Develop the attitude of wanting to help other people. This positive attitude will come across on the phone.
      4. Do not use standard phrases like, "Have a nice day," over and over again for every caller. Say something original that is appropriate to the person calling.

2. a. Determine the purpose of the call by listening to the caller and asking questions for clarification.
   b. Always obtain the caller's name and phone number if he/she is leaving a message or making an appointment.
   c. Repeat the information contained in the message back to the caller to make sure it is accurate.
3. d
4. I
5. I
6. E
7. I
8. E
9. Answers will vary, but should point out that the confidential nature of such information does not allow the person answering the phone to discuss the client's examinations over the phone. This would require the attorney to have a release signed by the client.

10. Answers will vary, but should state that the correct way to handle this situation would be to calmly explain that the doctor is with a client and cannot come to the phone, but would be able to return the call later. Take the caller's name and number, reading the information back for verification, then ask if there is anything else you can do to help.
11. a

LESSON PLAN: 8

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT II : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

EVALUATION ITEMS:

1. List two criteria for answering the telephone in a business or professional setting.

   a.

   b.

2. State the three steps in taking a phone message.

   a.

   b.

   c.

3. Which one of the following is the proper technique for terminating a telephone conversation? (Circle the letter of the best answer.)

   a. Hang up on the caller before he/she has finished talking.

   b. Say "Good-bye" and hang up.

   c. Tell the caller that he/she should try to come in person next time since you do not have time to keep answering the phone.

   d. Let the caller know that you are interested in him/her as a person by saying, "Thank you Mr./Mrs./Ms. ___ for calling. If there is anything else that I can help you with in the future, please let me know." Then wait for the caller to hang up.

   e. Tell the caller you are sorry you cannot talk longer but you have to go now because you are busy. Thank him/her for calling and say, "Have a nice day."

The following statements are examples of telephone techniques. Place the letter "I" in the blank if the statement is an example of an ineffective telephone technique, or the letter "E" if it is an example of an effective telephone technique.

___ 4. Wait until the phone rings at least twice before you answer it.

___ 5. If someone has a message to give you, tell them to hold on until you can find a pencil or pen to write with.

__ 6. If you are making several outgoing calls, space them several minutes apart so that people calling in will not keep getting a busy signal.

__ 7. If you are too busy to talk, tell the person to call back later.

__ 8. Repeat the caller's name, Mr./Mrs./Ms. ____, in the conversation.

Write a short answer to each of the following situations.

9. A client's attorney calls and states that he/she is preparing for a hearing and is scheduled for court tomorrow. He/she needs the list of exams that were completed on his/her client the previous week. How would you respond to this request?

10. Someone calls and demands to talk to the doctor immediately. The doctor is with a client. The caller is becoming increasingly irritated. How would you handle such a call?

11. Which of the following is not a tip on the proper use of fax machines? (Circle the letter of the best answer.)

    a. It is okay to send personal materials through the fax machine as long as nobody sees you send it.
    b. Handle all fax transmittals as confidential information.
    c. Do not leave incoming and outgoing transmittals in the machine.
    d. Send fax transmittals promptly.

HO 1

TELEPHONE TECHNIQUES FOR THE HEALTH PROFESSIONAL

The health professional must have a thorough knowledge of how to use the telephone. Never underestimate the importance of projecting a positive, professional image through your telephone personality. Remember, the caller cannot see you, and can only judge you by how you sound over the phone. Your professional voice and good telephone manners are essential elements in making a good impression.

There is a great difference between telephone conversation and face to face conversation. The friendly smile, congenial personality and warm gestures are not as apparent when meeting by telephone. Positive voice to voice meeting are created by the natural and sincere manner in which you speak. Avoid overused words or repetitious phrases, which tend to give the impression of insincerity. It is essential to give prospective as well as regular patients the impression that they are receiving personal attention and individual consideration.

In your role as a receptionist, you have many opportunities to relieve your employer of details and protect his/her prestige. Your job is doubly important on the telephone because you are representing a business. An employer depends on the receptionist to intercept and screen calls, and in many cases, handle the call rather than interrupt a doctor or other practitioner. No matter what the situation, you should always be pleasant, tactful, and diplomatic.

THE THREE PARTS OF THE TELEPHONE CALL

1. Identification (introduction)
    a. Answer promptly, make the first impression a favorable one by answering on the first ring.
    b. Provide proper identification. Identify your place of work and then state your first and last name and title. It is important to let the caller know that he or she has reached the right person.
    c. Answer in the manner in which your employer wishes you to--usually by saying, "This is the ____ department; ____ speaking, may I help you?"
    d. Do not answer with a number of an extension, i.e., "This is extension 671."
    e. Establish a courteous and friendly attitude.
    f. Be prepared to take written messages by having a pencil and note pad available.
2. Body of the call (purpose)
    a. This is the reason for the call, such as to make arrangements or plans, or to find out specific information.
    b. Always obtain the caller's name and telephone number.
    c. If the caller is a new client, ask who referred him/her.
    d. Never use the term "cancellation." It has a negative and harsh sound. Instead of "We have a cancellation," say, "We can get you in at ________."
    e. When taking a message, be accurate. Repeat the information to the caller to assure him/her that you have the correct information.
    f. If the caller is a new client, obtain address, phone number of home and business, and the correct spelling of his/her name.

3. Termination (conclusion)
    a. End the call in a sincere and agreeable manner.
    b. Let the caller know you were glad to be of service.
    c. Let the caller hang up first.

HOLDING THE TELEPHONE

1. Hold the telephone mouthpiece one-half to one inch away from your lips. Your voice is carried more clearly by the telephone if you hold the transmitter close to your mouth and if you speak directly into the phone. A good rule is: if two fingers are placed against the mouth piece and your lips against the fingers, even a person who is hearing impaired will be able to hear due to the vibrations of the transmitter. It is never necessary to shout into the telephone.
2. Never have anything in your mouth. Do not chew on a pencil or gum; do not smoke.

INEFFECTIVE TELEPHONE TECHNIQUES

1. Never say "hello" without providing proper identification.
2. Never demand information. Ask for information in a courteous manner.
3. Never give out information that may damage your employer's image.
4. Never contradict a client directly.
5. Never discuss the habits or problems of one client with another.
6. Never say no to an emergency.
7. Never use the term "okay" or other slang terms.
8. Never lose poise or become angry.
9. Never use the business phone for personal business.

EFFECTIVE TELEPHONE TECHNIQUES

1. Answer promptly.
2. Be prepared to take a message.
3. Be courteous even though a caller may be discourteous.
4. Repeat the caller's name several times during the conversation to give the caller a sense of familiarity.
5. Space outgoing calls to allow incoming calls to come through.
6. Retain the initiative. Learn when and how to cut off long-winded callers tactfully.
7. If more than one line is ringing and you must ask the caller to hold, take the name and telephone number of the second caller as quickly as possible and return to the first caller, apologizing for the delay.
8. If necessary, have the caller's file containing history and other information at hand. You will be prepared, and the call will be handled much more efficiently.
9. Screen calls in a businesslike manner.
10. If it is necessary to leave the phone, be sure to tell the caller how long you will be gone. Upon returning, greet him/her by name, and if there was an unavoidable delay, apologize.
11. Speak distinctly and unhurriedly.

Remember, the most important part of a telephone call is the closing. Always end your conversation with a few pleasant words: "Thank you for calling. It's good to speak to you again," or "I'm so glad you called that to my attention." By learning and practicing these techniques, you will make the most of a few moments of personal contact between you and someone who needs your help. You will look, sound, and feel professional.

USING PROPER TELEPHONE TECHNIQUES

The goal of this section is for you to feel more confident using the telephone.

1. Tips for answering the telephone

   a. Organize your work area. Know where your phone, message pad, company directory, and telephone book are. Be sure the phone and plenty of pens and pencils are within easy reach.

   b. Locate the incoming call on most multi-line phones by the flashing light. Push in the flashing button and pick up the receiver.

   c. Answer the call with a pleasant tone of voice. Give the name of your company and your first name.

   d. Speak clearly and don't mumble. Ask what the caller wants and determine how you may help him or her.

   e. Let yourself be interrupted when a call comes in. Don't let impatience show in your voice.

   f. If the caller wants a person or department that has another extension, connect the caller to the extension number. If someone who has no extension is asked for, go get the person. (Don't yell.)

2. Polite speaking and listening techniques.

   a. Whenever possible, answer the phone within three rings. Letting the phone ring longer gives the impression your company is poorly run.

   b. Listen carefully to the caller. Callers do not always know what they want. If so, you need to decide who the caller should talk to or what information the caller needs.

   c. If the caller is an unhappy customer, listen to the caller's entire story, even when the problem is not your fault.

      If the customer is upset by something the company did or didn't do, apologize briefly. This helps an angry customer cool off.

   d. Be pleasant. If you are pleasant, the caller will more likely use the services of your company again.

   e. Use the customer's name if he or she gives it. If the caller does not give his or her name, do not ask for it.

   f. Repeat some of the customer's own words as you ask questions and get more information. This shows the caller you are listening.

g. Let the caller interrupt you. Often the caller needs to "blow off steam" and does not mean to be personally rude.

h. Don't make personal out-going calls unless you do it on your time or you know it is O.K. with your company.

3. Taking Messages and Inquiries

To handle an incoming call:

a. Listen carefully to the reason the person is calling.

b. Decide if you need to take a message or answer a question.

c. Ask questions. Be sure you know what the caller wants. If you need to take a message, write it down. You will rarely remember it unless you write it down.

d. Be sure to ask the caller:

(1) the name of the person he or she wants,
(2) the caller's name,
(3) the nature of the business,
(4) the caller's phone number, and
(5) when the caller can be reached.

e. Confirm all information. Repeat to the caller any agreements or arrangements that have been made. Make sure the caller is satisfied with the arrangements before you hang up.

f. End the call pleasantly. Say goodbye and thank the person for calling. Let the caller hang up first. Do not hang up the receiver before you hear the caller hang up.

g. Do not slam the phone down when you hang up.

4. Using the telephone book

a. The telephone directory has six sections that help people find the number, name and location of businesses, people or agencies in the directory.

(1) Emergency Numbers. All emergency numbers are listed on the inside front cover or toward the beginning of the book so they can be found quickly in an emergency.

(2) Customer Guide. The Customer Guide, usually near the front, includes numbers for the telephone company's directory assistance, business, repair, billing and customer rights offices.

(3) The White Pages. The white pages carry listings for individual people and businesses. Numbers are listed in alphabetical order by the person's last name or the name of the business.

(4) The Yellow Pages. In the Yellow Pages, you find only businesses and agencies listed by category.

"Tony's Termites," for example, might be found under P for Pest Control. Categories in the Yellow Pages are organized alphabetically.

If a business is not listed under the category you expect, think of another name for the category. Sometimes the Yellow Pages will tell you to look under a different category.

(5) The Appendix. The Appendix usually carries a city or street map. Callers can use the map to locate an address within a city.

(6) Frequently Called Numbers. This section is usually found at the back of the phone book. It is a handy place to keep phone numbers you call often.

USING PROPER COMMUNICATION IN AN EMERGENCY

You must know and follow basic procedures in case of an emergency on the job. When you begin a job, be sure to get information about emergency procedures for employees. Because each company's procedures may be different, you need to know the details.

The biggest rule in any crisis is: DON'T PANIC -- STAY CALM.

To communicate properly in an emergency, you must try to think calmly and speak calmly to other people. Don't let your panic take over your thoughts and voice, or you will not be able to communicate.

1. Be able to tell others calmly where emergency equipment is located. Learn where the fire extinguishers are located and how to operate them. Learn where the first-aid kit is located.

2. Be able to tell others calmly where emergency exits are located. Remind them calmly to walk -- NOT RUN -- to the exits.

3. Know, or know where to find, emergency phone numbers for the fire department, rescue service, poison control and hospital. Make sure the numbers are displayed in an obvious place. In an emergency, you may not have time to locate the numbers in a phone book.

4. During a Crisis

    a. Don't panic. Assess the situation and decide what is your best move. Keep others calm.

    b. Report the emergency to your supervisor as soon as you can. Follow his or her instructions. He or she may want you to call the proper authorities.

    c. If your supervisor is not available, you must decide what needs to be done. In an emergency, it is usually best to phone the proper authorities (fire department, police, ambulance, etc) even if your supervisor has not told you to.

       As calmly as possible, tell the person who answers (1) your name, (2) your address, (3) what has happened, and anything else the person asks for.

    d. When there is an injured person, if possible, do not move the person. It sometimes causes further injury. Only move a person when their life is in danger.

LESSON PLAN: 9

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III: SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the health care assistant in fire and disaster safety and using body mechanics to position the client. It is vital to our clients' and our own well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: III-9 OR DEMONSTRATION:

SAFETY MEASURES FOR THE CLIENT AND THE ENVIRONMENT

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify causes of accidents.
2. List which clients require specific safety measures.
3. Identify ways the health care assistant can help prevent falls.
4. Identify ways the health care assistant can help prevent fires and burns.
5. Identify ways the health care assistant can help prevent poisoning.
6. Describe nursing care measures to ensure client safety.
7. List two reasons for applying safety devices.
8. Describe the use of safety devices.
9. Identify principles in applying restraints.
10. Identify safety measures for a safe environment.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Alternatives to Restraints
2. HO 2: Safety Guidelines: Infant Through Adolescents

3. HO 3: Restraints

4. Bed with side rails

5. Safety vest or jacket

6. Posey/safety belt

7. Wrist/ankle restraint

8. Roll belt

9. Mitten

10. Transfer belt

11. Hydraulic lift

12. Cardiopulmonary Resuscitation, video #10, available from the Missouri Vocational Resource Center, 14 min.

13. Audiovisuals available from the Missouri Division of Aging Film Library

    a. Environmental Quality Assessment, video (TF #163)
    b. Patient Restraints, video (TF #104), 15 to 60 min.

14. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 9 (Student Reference page 145) prior to class and be prepared to discuss the information presented.

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INTRODUCTION:

The health care assistant must be very conscious of any condition that may cause an accident. A client who receives an injury from an accident may require many days of hospitalization or rehabilitation. This can be very costly and may result in the client's loss of independence, or even death.

Safety is a basic need of every human. The health care client is frequently dependent upon the caregiver to provide safety for him/her. It is a responsibility of the health care assistant to monitor for and report anything that may lead to an accident or injury of a client, visitor, or staff member.

More Missourians are hospitalized from falls than for any other injury. In 1990, 18,643 people were hospitalized because of falls. Adults over the age of 65 are most at risk from dying or suffering severe long-term effects from injuries due to falls. The elderly are more likely to have fall-related injuries to the spinal column or cord. Children are most likely to have fall-related injuries to the head. Another 11,020 individuals were hospitalized in 1990 because of poisoning.

In an average week across Missouri, 7 people will die from falls, 359 will require hospitalization due to falls, 2 will die from poisoning, 91 will require hospitalization due to poisoning, 2 will die from burns or fires, and 22 will be hospitalized due to exposure to fires.

In particular, infants and children must be protected from injury. They like to explore their surroundings which may result in falls, poisoning, choking, and burns. Remember, children love to put objects in their mouths and they touch and feel everything around them.

LESSON PLAN: 9

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

OUTLINE:

I. Causes of Accidents (II-1)

- A. Usually a combination of causes
- B. Dizziness caused by lack of oxygen to brain or low blood sugar
- C. Tumors - cause loss of balance
- D. Tremors
- E. Loss of balance during postural changes
- F. Visual changes - especially depth perception
- G. Confusion
- H. Forgetfulness
- I. Change in furniture arrangements
- J. Unlighted halls
- K. Inadequately identified medications
- L. Wet floors or other floor hazards
- M. Crib rails left down
- N. Unattended infants and small children
- O. Open electrical outlets that children can put their mouths on
- P. Medications and household products that children can reach and open
- Q. Loose parts or sharp edges on toys
- R. Propped baby bottles
- S. Stairs

II. Client Conditions that Require Specific Safety Measures (HO 2) **(II-2)**

- A. Confused - due to medication, poor nutritional status, emotional disturbance, disease of brain, or disease of cardiovascular system
- B. Elderly
  1. Aging process - there is a decrease in the senses (taste, touch, smell, hearing, and vision): client is less aware of danger warning signals
  2. It takes longer to react to danger.
- C. Client sedated with drugs
- D. Unconscious client

III. Falls **(II-3)**

- A. Cause
  1. Result of tripping, slipping, climbing, or reaching for items (can occur at any age)
  2. Shoes
  3. Loose clothing which is too long
  4. Tripping over items in walk areas or doorsills
  5. Tripping over loose cords
  6. Stairs
  7. Wax on floors
  8. Spills of any kind
  9. Worn uneven rubber tips on canes and walkers
  10. Slipping in bathroom
  11. Loss of balance when getting on and off the toilet seat
  12. Unsupervised young children going up and down stairs
- B. Prevention
  1. Always change position of client slowly. This provides time for the client to gain equilibrium (balance).

NOTE: Do not leave a client alone immediately following a change in position.

2. Shoes should be well-fitting with broad, low heels. Bedroom slippers do not offer support.
3. Shoelaces must be tied.
4. Clothing should not be too long or very loose.
5. Remove any obstacles from floors.
6. Wipe up spills immediately.
7. Report to charge nurse if a client complains of dizziness, prone to falling, has an unsteady gait, slides out of wheelchair, or tries to climb over side rails.
8. Report broken equipment immediately.
9. Use equipment according to facility policy.
10. Report immediately any unsafe hazards such as leaks in the bathroom or shower, loose handrails, loose carpeting.
11. Answer call lights promptly and make certain they are functioning.
12. Properly position clients.
13. Follow facility procedure regarding side rails and crib rails. Side rails and crib rails are a frequent cause of falls.
14. When transferring clients, make certain wheelchairs, beds, commodes, and stretchers have wheels locked.
15. The bed adjustment handle should be in the "in" position when not being used.
16. Use nonslip strips or rubber mat in the tub or shower.
17. Leave beds in the lowest horizontal position when not giving care.
18. Orient client to any change in furniture location.
19. Report any lights which are burned out.
20. Use gait belt properly.
21. All tubs and showers should have chairs.

22. Avoid using bath oil in the tub; it makes the tub slippery.

23. Never leave children unattended in high chairs or walkers.

24. Do not allow children to climb up and down stairs.

IV. Fire and Burns (II-4)

A. Causes in elderly

1. The elderly have a decreased awareness of sensations of pain and temperature.

2. Confusion - forgetfulness

3. Smoking

4. Oxygen in use

5. Electrical overload, frayed wires, loose connections

B. Causes in children

1. Hot liquids that can be reached

2. Matches or cigarette lighters

3. Stoves or fireplaces

C. Prevention of fires and burns

1. Restrict smoking to supervised areas. Fire laws prohibit smoking in bed when the client is unattended. Most hospitals do not allow smoking the building.

2. Immediately report any client seen with matches or lighters who does not have permission to carry them.

3. If oxygen is in use, take special precautions.

   a. Turn oxygen off when not in use.

   b. No open flames in the area - cigarettes

   c. Use no flammable liquids such as nail polish or alcohol on client; no petroleum-based products on face

   d. Do not use electrical equipment such as razors or radios.

   e. Visitors must follow oxygen precautions. Warn them.

4. Check water temperature in shower, tub, and whirlpool. CAUTION: Electronic thermometers may not always be accurate.

5. Assist clients at meal time to prevent spills of hot liquids.

6. Use only cotton blankets on beds.

7. Know the location of fire extinguishers and how to use them.

8. Know the facility's written plan to be followed in case of a fire for evacuating clients.

9. Immediately report any signs of electrical overload, frayed wires or loose connections.

10. Keep cigarette lighters and matches out of the reach of children

11. Supervise children.

D. In case of fire:

1. Immediately move the client to safety.

2. Once the client(s) is safe, sound the alarm.

3. Once the alarm is sounded, follow the evacuation plan as practiced.

DO NOT PANIC!!!

V. Poisoning - occurs more often in children but can occur at any age (II-5)

A. Cause

1. Client mistakenly drinks a harmful liquid.

2. Visitor brings in medication and it is taken by another client.

3. The medicine room door is not locked when unattended.

4. Clients hoarding medications.

5. Medications and household products left where children can reach them.

B. Prevention

1. Make certain no harmful liquids or medications are left where the client might swallow them - cleaning solutions, fingernail polish remover, unauthorized medications, lighter fluid, insect spray, aspirin, etc. Store in a high, locked area.

2. Immediately report unlocked medication room.

3. Make certain everything is labeled.

4. Buy products with child-proof caps.

(II-6)

VI. Safety Measures for All Clients (HOs 1 & 2)

A. Check eyeglasses for cleanliness and labeling; make sure client wears his/her own glasses.

B. Check hearing aid to make sure it is functioning properly; make sure client wears it.

C. Handle mechanical aids with care; can be expensive to replace if damaged.

D. Place signal cord within reach of client at all times; client may injure self trying to get to it.

E. Check bed brakes; should be in lock position unless moving the bed.

F. Side rails should be up when indicated, check with charge nurse.

G. Keep bed in low position to decrease danger of falls.

H. When feeding clients, take precautions to avoid burns from hot food.

I. Give instructions clearly to prepare client for an activity.

J. Allow smoking only under supervision and in approved areas. Supervise clients when they smoke, particularly if weak, unsteady, or confused.

K. Allow clients to adjust to changes in position before asking them to move.

L. Lock brakes on wheelchair, shower chair, or geri-chair when not being moved.

M. When bathing clients, use a bath thermometer to avoid burning the client.

N. Correctly apply all safety devices.

O. Assess client's ability to ambulate; check for:

1. Unsteady gait

2. Unbalanced - holds on to objects

3. Posture

4. Complaints of dizziness

P. Be alert to the potential hazards of swinging doors opening into rooms.

Q. Monitor clients who may wander away.

R. Report to the charge nurse immediately if you think a client is a danger to himself/herself or others.

S. Make certain all electrical outlets have safety plugs.

T. Always supervise children. Never leave them alone.

VII. Reasons for Using Safety Devices **(II-7)**

A. To help a client maintain proper body position and balance

B. To ensure client's safety

C. To keep a confused client from disrupting a treatment procedure, such as an IV, Naso-gastric tube, or dressing

D. To prevent a severely emotionally disturbed client from injuring himself/herself or others

VIII. Safety Devices (HO 3) **(II-8)**

A. Bed side rails - a frequent cause of falls

1. Metal frames placed on sides of bed
2. Prevent client from falling out
3. Do not prevent client from climbing out
4. Must be securely attached
5. May be used for clients who are blind, confused, unconscious, sedated, have muscular disabilities, or seizures
6. Rails may be lowered while working at bedside.
7. Remember to raise before leaving client; be sure both sides are up as instructed by charge nurse.
8. Always explain the purpose.
9. Make sure call light is within reach.
10. Many health care facilities leave side rails down on one side for clients who can safely transfer without help.

    11. At times, half side rails are used.

B. Safety jacket or vest

    1. Canvas or mesh vest with tails that are crossed and tied behind the client's chair or tied to the movable portion of the bed frame should never be attached to bed side rails.

    2. Never use while client is on a bedside commode or toilet.

    3. Avoid wrinkles or knots that may exert pressure on the client's skin.

    4. Check and exercise client as directed by charge nurse. Never go longer than 30 minutes without checking jacket. Exercise client at least every two hours.

C. Safety belt

    1. Canvas or cloth strap large enough to be placed around the client's waist and tied to the movable portion of the bed frame on both sides

    2. Serves the same function as safety vest; used for same reasons

    3. Check skin for any signs of pressure: discoloration of skin, indentations, redness

    4. Check and exercise client as directed by charge nurse. Never go longer than 30 minutes without checking belt. Exercise client at least every two hours.

D. Wrist or ankle restraints

    1. A soft-type cloth such as linen or muslin is used to form a strap that slips on the wrist or ankle and ties to the bed frame. Padding should be placed on the limb before applying restraint to prevent skin irritation.

    2. Use only as directed by charge nurse.

    3. A thorough explanation should be given to the client before applying the restraint.

    4. Apply the restraint in such a manner that the client will not tighten it if he/she pulls on it.

    5. Check and exercise client as directed by charge nurse. Never go longer than 30 minutes without checking restraint. Exercise client at least every two hours.

6. Check circulation for impairment due to a restraint that is applied too tightly. Also check to be sure the limb is not restrained in an abnormal position.

7. Signs of impaired circulation

    a. Blueness

    b. Pallor

    c. Skin is cool or cold to touch

    d. Client complains of tingling sensation

8. Restore circulation if any of the above signs are noted by loosening restraint and exercising and gently massaging limb.

E. Mittens

1. A device made of soft material that completely covers the hand; it prevents grasping but does not restrict movement.

2. Check circulation as stated for wrist or ankle restraints.

3. Check and exercise client as directed by charge nurse. Never go longer than 30 minutes without checking mittens. Exercise client at least every two hours.

F. Transfer belt (often called gait belt)

1. Canvas belt with an adjustable buckle; used when transferring or ambulating client

2. Placed around the client's waist

3. Should never be used as a restraint

G. Hydraulic lift

1. A hydraulic lift with a one-piece canvas sling for transferring the extremely heavy or handicapped client

2. Use discretion and common sense in determining if a severely spastic or handicapped client can be lifted with the lift

IX. Principles of Applying Restraints or Safety Devices **(II-9)**

A. Restraints or safety devises are one of the biggest causes of immobility in long-term care facilities. Immobility causes:

   1. Skin break down
   2. Circulation to be restricted to an area
   3. Loss of muscle tone
   4. Stiff joints

B. Client may become:
   1. Hostile
   2. Disoriented
   3. Agitated
   4. Withdrawn
   5. Despondent; loss of the will to live

C. OBRA regulations
   1. Restraints may be used only as a last result.
   2. Alternatives to restraints must have been tried, documented, and failed.

D. Health care assistant's responsibilities if restraints are used:
   1. Report to charge nurse all client behavior so it can be documented.
   2. Document all alternatives that were tried.
   3. Always check with charge nurse before applying a restraint. An order for restraints must be obtained from the physician by the charge nurse.
   4. Try to use the least restrictive device first.
   5. Follow the manufacture's directions when applying a safety device.
   6. Check the client at least every 30 minutes.
   7. Restraints are released every two (2) hours.
      a. If possible, assist the client to walk.
      b. For a client who cannot ambulate, do passive range of motion exercise.
      c. Assist client to the bathroom or offer the bedpan.

d. Make certain the client is clean and dry. Give skin care.

8. Check the client's skin for redness, skin break down, and irritation.

9. Give fluids.

10. Place the call light within reach of the client.

11. A geriatric chair (geri-chair) is a rolling chair with a high back that has a removable tray. It should not be pushed too tightly against the client's waist.

12. Put padding on any skin area that may be irritated by application of the safety device.

13. Give the client the most movement possible, but still ensure safety. Secure ties where the client cannot reach them and undo them.

14. Ask client and family to notify the nursing staff if the restraint is causing discomfort.

15. Provide pillow props (positioning of soft props) as needed to assure good body alignment.

X. Safety Measures for the Environment **(II-10)**

A. Clean up untidy conditions in the client's room.

B. Keep all walkways free of hazards, such as shoes, chairs, and bed cranks.

C. Wipe up spills according to facility policy. Post a "Wet Floor" sign if needed while it is drying.

D. Encourage use of handrails and grab bars in the shower, bathroom, and hallways.

E. Examine wheelchairs, shower chairs, geri-chairs, walkers, and other equipment for broken parts; if any are found, report to charge nurse.

F. Never handle electrical equipment with wet hands or near water.

G. Report extension cord use to charge nurse.

H. Inspect cord and plugs for fraying or defects before plugging in. Never place cords over client.

I. Report any equipment that causes electrical shock when handled.

J. Post emergency phone numbers near each telephone.

K. Leave articles such as water glasses, wipes, and signal devices within reach of client.

L. Provide adequate lighting.

M. Keep hallways clear. NEVER place anything in front of a fire extinguisher.

XI. Summary and Conclusion

A. Causes of accidents

B. Client conditions that require specific safety measures

C. Falls

D. Fires and burns

E. Poisoning

F. Safety measures for all clients

G. Reasons for using safety devices

H. Safety devices

I. Principles in applying restraints or safety devices

J. Safety measures for the environment

As a health care assistant, you have the responsibility of providing safety for your clients. Keep these factors in mind every minute while at work. It is extremely important because so many of your clients are dependent upon you to meet this basic human need. The next lesson is on fire, natural disasters, and other emergencies.

LESSON PLAN: 9

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III: SAFETY

INTERACTION ITEMS:

1. What are some causes of accidents?
2. What type of clients may require more frequent observance of safety factors?
3. What can the health care assistant do to prevent falls?
4. What can the health care assistant do to prevent fires and burns?
5. What can the health care assistant do to help prevent poisoning?
6. When taking care of client what are some safety measures to keep in mind?
7. What are some reasons for applying a restraint?
8. How are safety devices used: bed side rails, safety jacket or vest, safety posey belt, wrist or ankle restraints, mittens, transfer belt, and hydraulic lift?
9. What are twelve principles of applying restraints?
10. What safety measures are necessary for a safe environment?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students restrained during class with various restraints.
2. Have students locate brakes on beds, wheelchair, geri-chair, and shower chairs and apply brake and release.
3. Demonstrate application of each type of restraint.
4. Have students practice applying restraints on each other.
5. Discuss students' feelings about being restrained.
6. Have a class discussion on alternatives to restraints.

ANSWERS TO EVALUATION ITEMS:

1. d

2. The student may list any two of the following:
    a. Confused
    b. Elderly
    c. Client sedated with drugs
    d. Unconscious

3. b
4. a
5. c
6. b
7. a
8. c
9. 30
10. c
11. a
12. b
13. b
14. c
15. a
16. d
17. T
18. F
19. F
20. T
21. F
22. F
23. T
24. F
25. F
26. T
27. T
28. F
29. T

LESSON PLAN: 9
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT III : SAFETY

EVALUATION ITEMS:

1. Some common causes of accidents include all but one of the following. Which one of the following is not a common cause of accidents? (Circle the letter of the best answer.)

   a. Loss of balance
   b. Change in furniture arrangements
   c. Unlighted halls
   d. Excessive weight gain

2. List two client conditions that may require specific safety measures.

   a.

   b.

Match the following types of accidents in Column II with measures of prevention health care assistants can take in Column I.

	Column I		Column II
___ 3.	Reports client seen with matches or lighters.	a.	Falls
___ 4.	Wipe up spills immediately.	b.	Fires & burns
___ 5.	Keep harmful liquids out of the reach of clients.	c.	Poisoning
___ 6.	Do not use electrical equipment around oxygen.		
___ 7.	Answer signal lights promptly.		
___ 8.	Immediately report unlocked medication room.		

9. Clients wearing restraints should always be checked and exercised as directed by charge nurse. Never go longer than ______ minutes without checking the restraint. Exercise the client as least every two hours. (Fill in the blank.)

10. Nursing care measures for client safety are: (Circle the letter of the best answer.)

    a. Keep the bed in the high position at all times.
    b. Bed brakes should be in the unlocked position.
    c. Place signal light within reach of the client at all times.
    d. Allow clients to smoke in any area they choose.

11. The only reason for using a safety device or restraint is: (Circle the letter of the best answer.)

    a. To ensure client's safety
    b. To ensure you know where the client is at all times
    c. To make your job easier
    d. To make family feel better

12. All of the following except one are true statements concerning bed rails. Which statement is false? (Circle the letter of the best answer.)

    a. Bed rails are used for clients who are blind, confused, unconscious, or sedated.
    b. Bed rails must always be up when giving the client care.
    c. Bed rails do not prevent the client from climbing out of bed.
    d. Bed rails must be securely attached to the bed.

13. The client who has a wrist or ankle restraint should be checked for signs of impaired circulation. Signs of impaired circulation are: (Circle the letter of the best answer.)

    a. Skin warm to the touch
    b. Blueness and pallor of the skin
    c. Dizziness
    d. Flushed skin

14. A mitten prevents: (Circle the letter of the best answer.)

    a. Movement of the thumb and fingers
    b. Movement of the thumb
    c. Grasping
    d. Circulation to fingers

15. All of the following are true statements concerning OBRA regulations in regard to restraints except one. Which one of the following statements is false? (Circle the letter of the best answer.)

    a. Restraints may be applied if the health care assistant feels they are needed.
    b. Other alternatives to restraints must be tried, documented, and failed before restraints are applied.
    c. A written consent from the client, guardian, or family must be obtained before applying restraints.
    d. Restraints may be used only as a last resort.

16. Safety measures for the environment include: (Circle the letter of the best answer.)

   a. When you see spilled water in the hallway, ask house keeping to clean it up.
   b. Leave water pitcher and water glass on the window sill.
   c. Keep lighting in the room off or low to prevent glare.
   d. Encourage use of handrails and grab bars in the shower, bathroom and hallway.

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 17. Keeping the bed in the lower position will decrease the danger of falls.

____ 18. Eyeglasses have nothing to do with safety for the client.

____ 19. Bed brakes should be unlocked at all times.

____ 20. Allow the client to adjust from a lying down (supine) to sitting up position before transferring to a chair.

____ 21. The only reason to apply a safety device is to ensure a client's safety.

____ 22. It is not appropriate to lower a side rail while you are working at that side of the bed.

____ 23. A physician's order is needed to apply restraints unless it is an emergency situation.

____ 24. The more restraints the health care assistant can use on a client, the better protected they will be.

____ 25. No explanation should be given to clients when applying restraints because this makes them harder to control.

____ 26. Clients should be allowed as much movement as possible but kept within limits of safety.

____ 27. Extra padding should be used if the client's skin is very thin.

____ 28. Only housekeeping tidies up the client's room.

____ 29. Wipe up any spills on the floor immediately.

ALTERNATIVES TO RESTRAINTS

Seating

1. Comfortable, well-fitted chairs. (Consult with O.T. and/or P.T. for input for proper seating.)

2. Soft, comfortable, wing-chairs will often provide similar relaxation for the anxious client.

3. Wheelchairs should be used for transportation only. If a client is not able to propel wheelchair independently, he/she should be seated in it only for transport purposes.

4. Vary the locations where an individual sits. Sometimes quiet areas are appreciated, but often clients want to be "where the action is".

5. Sturdy rocking chairs may help fill need for constant motion (Vestibular Stimulation).

6. Foam, wedge-shaped seat cushions will often keep the client from sliding out of chair. (Be sure the thickest edge is at front of chair.)

7. Geri-chairs are restraints and a complete assessment must be done before using them.

Activities

1. Occupy much of your clients' waking hours with scheduled activities. Provide a purposeful routine in their lives - O.T., P.T., recreation, special sessions for special needs.

2. Provide planned, daily exercise (calisthenics geared to older people - walks and other outside activities).

Wandering

1. Accept the fact that restless, anxious clients must be allowed to walk when able. Make the environment as safe as possible and allow them freedom to move about.

2. Sometimes one-on-one attention is necessary while working through a crisis. Enlist all facility staff to do their part in keeping track of a wandering client. It's not just a nursing responsibility! Give a staff member the responsibility for a wanderer in small blocks of time. Anyone can do it for short periods. It's a very tiresome, frustrating job for long stretches, and the caregiver will lose interest.

3. Placing a bright yellow barrier strip across the doorway of an alert client will often deter a wandering client from entering the room. Always get permission from the alert client to place the barrier strip.

Sleeping

1. Hi-Lo beds which can be lowered close to the floor are very important.

2. Side rails are usually considered restraints. Often they provide security and can be used as grab bars for turning in bed. One-half or three-quarter side rails are best for preventing the necessity of climbing over rails or foot boards to get out of bed. It may be necessary to pad the floor area if there is a risk of the client falling from the bed.

3. In severe situations, consider putting the mattress on the floor and making the bed there. Only in severe situations.

4. Understand that sleep often does not come easily as we grow older, and if it doesn't, it's very difficult to remain in bed. Caring for older people means some clients will be awake and out of bed during the night.

5. Certain electronic bed checking systems can alert the nurse when a client is trying to get out of bed. Some facilities have used it with success.

Environment

1. Allow clients to surround themselves with furniture and possessions which are of personal importance. This helps in recognition of their room and provides a comfortable, secure haven in an often strange environment.

2. Full length mirrors at exit points sometimes distract the wanderer.

3. Provide handrails on both sides of toilet.

4. Remove wheels from overbed table if client leans on it for support. If this is not possible, remove it from the room.

5. A raised toilet seat often makes transfers easier.

6. Eliminate, or at least reduce, the use of public address or paging systems. Voices coming over these systems are stressful and confusing for frail clients.

Falling

1. Be sure the client wears comfortable, well-fitted shoes.

2. Constantly monitor your facility for safety hazards.

3. Provide O.T. and P.T. regularly to maintain strength and to identify risks.

Relationships: Nurse-Client-Family

1. It is important to organize the nursing staff in a way that a client has the same caregiver week after week. In this way, the caregiver knows the needs of the clients he/she cares for and provides valuable input for an individualized plan of care.

2. Maintain good, caring relationships with client's family and include their input in the client's plan of care. Family members also provide valuable insights in understanding client behavior.

3. Understand that each client is an individual with his/her own personal needs. Care must be "customized" for the client's particular situation. What works for one situation may not work for another. Keep trying, that's our mission as caregivers.

Adapted from: Untie the Elderly - Quality Care without Restraints. Senate Print 101-90, U.S. Senate Special Committee on Aging, 1990.

SAFETY GUIDELINES: INFANT THROUGH ADOLESCENTS

Safety Guidelines for Infants

- Crib side rails must be up at all times
- Keep one hand on the infant when side rails are down. Don't take your eyes off the infant.
- Use crib bumpers or rolled blankets to prevent injuries.
- Don't lay infant on abdomen to sleep.
- Keep toys with small removable parts or pointed objects away from infants.
- Never tie balloons on cribs.
- Never prop bottles up for the infant to suck.
- Never tape pacifiers in an infant's mouth.
- Restraints for Infants
    - An infant is considered to be incompetent. A Doctor's order is not necessary to restrain an infant.
    - Restraints are only used to protect the infant. Restraints are never tied to the crib side rail, tie to the crib frame.

Safety Guidelines for Toddlers (age 1 to 3 years)

- Keep medication and anything poisonous in a locked cabinet out of reach of the toddler.
- Always remain with the toddler when they are in the bathroom or bathtub.
- Keep side rails up at all times.
- Do not give toddlers balloons to play with.
- Do not let toddlers play with toys that have removable parts, strings, or sharp points.
- Keep doors to stairs and medication and treatment rooms locked whenever possible.

Safety Guidelines Preschool Child. (age 3 to 6 years)

- Keep side rails up when child is in bed.
- Bed should always be in the low position.
- Pick up toys to prevent falls.
- Keep doors to storage rooms and kitchen closed.
- Stay with child when in the bath tub.
- Don't allow children to run with anything (e.g., suckers, pencils) in their mouths.

Safety Guidelines for the School Age Child (age 6-12 years)

- Keep cleaning solution and poisonous materials out of reach.
- Keep bed in low position and side rails up when child is in bed.
- Don't allow children to play with dangerous toy's, guns, or knives.

Safety Guidelines Adolescents

- Check all electrical equipment (hair dryer, razor, radio, etc.) that they bring with them to the hospital. Make certain the equipment meets all hospital guidelines.
- Review facility policies regarding smoking, alcohol, and drugs.
- Remind them to tell you if they leave their room.
- Keep bed in low position.

RESTRAINTS

I. Physical Restraints - Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the client's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

A. Examples

1. Waist
2. Vest
3. Belt
4. Pelvic
5. Wrist
6. Geri-Chair
7. Mitt
8. Pelvic Rollbar
9. Houdini
10. Halters
11. Full side rails (which are used to restrain rather than enable)

B. Purpose - prevent violence or harm to oneself or others

C. When not to use restraints

1. Punishment
2. Instead of additional staff
3. Convenience
4. Because of custom or based on fear
   NOTE: Consideration of litigation varies from site to site and should not be the justification for use of restraints as an automatic measure

II. Chemical Restraints - Psychoactive drugs should never be used for discipline or convenience.

III. Passive Physical Restraints - A physical appliance which is adjacent to but not bodily attached to the client but does restrict some freedom of movement and may restrict normal access to certain parts of one's body.

A. Examples
1. Wheelchair roll bars
2. Geri-chair with tray

B. Wheelchair/Geriatric Chair - Safety bar kits may or may not be considered restrictive devices. Many "Restraint-free" facilities use bars with non-locking closures to help provide security without restraints.

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety and using body mechanics to position the client. It is vital to our clients' and our own well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: III-10 AND DEMONSTRATION: III-10

FIRE, NATURAL DISASTERS, AND OTHER EMERGENCIES
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. Identify methods of fire prevention.
3. Describe what to do in case of fire.
4. Distinguish between a tornado watch and a tornado warning.
5. Discuss what actions should be taken should an earthquake occur.
6. Identify steps to control hemorrhage from a cut.
7. Explain the proper steps to follow should a client fall.
8. List observations that should be made during a seizure.
9. Identify precautions to avoid choking while feeding a client.
10. Describe cardiopulmonary resuscitation, CPR.

Demonstration

11. Clear airway of obstruction in conscious client according to steps of procedure.
12. Clear airway of obstruction in unconscious client according to steps of procedure.

13. Perform cardiopulmonary resuscitation (CPR).

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Moving Client to Safety
2. HO 2: Safely Handling a Falling Client
3. HO 3: First Aid for the Choking Victim (Adult)
4. Fire extinguishers
5. Facility floor plan
6. Drop, Drag, and Carry, film, from Fire Prevention through Films, Inc.
7. How to Save a Choking Victim--the Heimlich Maneuver, film, check local libraries, county libraries, health departments, etc.
8. Projector
9. CPR equipment

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 10 (Student Reference page 167) prior to class and be prepared to discuss the information presented and return the demonstrations.

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INTRODUCTION:

The health care assistant must be aware of what to do if faced with a disaster or emergency. Many times we do not think about these things beforehand. It is necessary for you to concentrate on this information since these are *not* everyday occurrences. An emergency requires quick action, and clients depend upon you for assistance and reassurance.

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

OUTLINE:

I. Terms and Definitions (II-1)

  A. Emergency - an event that calls for immediate action

  B. Extremities - the arms, legs, hands, and feet

  C. Hazard - a source of potential danger

  D. Hemorrhage - excessive, uncontrolled bleeding

  E. Incident - an unusual event or occurrence

  F. Obese - extremely fat

  G. Immobile - unable to move

  H. Obstruction - a blockage

  I. Impairment - that which hinders proper function

  J. Seizure - sudden, periodic attacks of muscles contracting and relaxing

  K. Oxygen - a colorless, odorless gas that is essential for breathing

  L. Supine - lying on one's back

  M. Cardiopulmonary resuscitation - an emergency procedure used to establish effective circulation and respiration to a victim whose heart has stopped beating

  N. Unconscious - an individual's lacking in awareness

  O. Ventilate - give air to

II. Fire Prevention (II-2)

  A. Smoking is the number one cause of fires in health care institutions.

  B. You must know smoking regulations of the health care facility.

C. Never empty ashtrays into any container that may contain flammable materials.

D. Allow smoking only under supervision and in approved areas.

E. Study and understand the fire evacuation plan.

F. Know the facility's floor plan and location of all fire alarms.

G. Know locations of fire extinguishers and how to use each type.

H. Never prop open a fire door.

I. Participate in fire drills.

J. Exits and fire extinguishers should be clearly designated and not obstructed.

K. Report any fire hazards you find to charge personnel immediately. Example - cluttered halls.

L. Do not use extension cords except as a temporary measure and then for only one appliance and not more than six feet in length.

M. Have scissors within easy reach to remove safety devices in case of an emergency.

N. Know precautions needed for storage and use of oxygen.

O. Use proper precautions with combustible cleaning compounds.

P. Follow facility policies regarding lights, Christmas trees, appliances, etc.

III. In Case of Fire **(II-3, 4)**

A. Remove client(s) from the area of immediate danger to the nearest safe area.

B. Close the door of that room as you leave. This is an absolute must if the fire is in that room.

C. Notify the fire department immediately.

D. Calmly notify another employee in the facility of the fire--preferably the charge nurse.

E. All employees proceed to their assigned fire stations and begin preassigned duties, such as closing fire and smoke doors and windows, removing additional clients adjacent to danger area, and shutting off mechanical equipment.

F. Attempt to extinguish the fire with the proper fire extinguisher; remember to always feel door before entering; if warm to touch, wait and let fire department handle it. Three types of fire extinguishers:

  1. Water - used for ordinary combustible fires

  2. Chemical - used for flammable liquid fires and electrical equipment fires

  3. Foam - used for flammable liquid fires

G. Evacuation instructions

  1. Clients near fire or smoke must be evacuated first.

  2. Remove ambulatory clients first, then wheelchair clients, and then the bedridden clients last.

  3. Be able to perform various client carries. (HO 1)

  4. Your primary concern and first responsibility is always the clients' safety.

  5. A staff member must remain with the evacuated clients to prevent any of them from re-entering the facility.

H. Remember, the first five minutes of a fire are more critical than the next five hours.

I. Cover mouth and nose with wet washcloth or towel to reduce smoke inhalation.

J. Never use an elevator during a fire.

IV. Tornado Safety **(II-5, 6)**

A. The average tornado lasts from eight to ten seconds.

B. Hail often immediately precedes a tornado.

C. Tornado watch

  1. Is announced when conditions are such that a tornado may develop. Be very alert if you hear there is a tornado watch.

  2. Radio and/or television should be on and someone assigned to listen to local station for weather reports.

  3. Flashlights should be secured and all staff members aware of weather conditions.

  4. Proceed with the following as requested by the charge nurse:

a. Clear windowsills of all objects; put all heavy, sharp, or glass objects and plants in closets or drawers.

b. If clients are up in chairs, do not put them back in bed.

c. Move bedridden clients into chairs, or put overbed table and blanket next to the bed so they can be positioned over the client's face when needed.

d. Check outside areas for loose objects such as chairs, vases, garden tools, etc., and bring them inside.

e. Close doors to client rooms securely; close fire doors to prevent wind-tunnel effect in halls.

D. Tornado warning

1. Occurs when a tornado has been identified within the local area of a community. Be extremely alert if you hear there is a tornado warning.

2. Alarms will be sounded.

3. Clear all large rooms (dining room, activities room, etc.) of all clients and staff personnel.

4. Move all clients into hallways near exits or into closets, or away from windows.

5. Bedridden clients may remain in bed--push the bed against the door wall; pull window curtains and privacy curtains. Extra blankets should be applied.

6. Close doors to client rooms securely; close fire doors.

7. Do not block any doorways to hall, fire doors, or exit ways.

8. Cover clients in hallways with blankets or bedspreads to protect them from flying glass.

9. Continue to monitor weather reports.

E. After tornado

1. Restore calm to clients.

2. Check all clients for injuries and other ill effects.

3. Check for fires throughout the facility.

4. Follow charge nurse's instructions.

V. Earthquake Safety **(II-7)**

A. During an earthquake, the "solid" earth moves like the deck of a ship. The actual movement of the ground, however, is seldom the direct cause of death or injury. Most casualties result from falling objects and debris because the shocks can shake, damage, or demolish buildings. Earthquakes may also trigger landslides or cause fires.

B. If an earthquake occurs, try to STAY CALM. Think before you act and stay where you are. During the actual earthquake, you will be unable to help clients. Protect yourself so you can help them later.

1. If inside, stay there; take cover under a heavy object like a desk, table, or bench, in a supported doorway, or along an inside wall. Do not use candles, matches, or other open flame either during or after the tremor because of possible gas leaks.

2. If outside, stay there; move away from buildings and utility wires. The greatest danger from falling debris is just outside doorways and close to outer walls. Once in the open, stay there until the shaking stops.

C. After the earthquake

1. Be prepared for additional earthquake shocks.

2. Check for injuries. Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.

3. Listen to the radio or television to get the latest emergency information from local authorities.

4. Do not touch downed power lines or objects in contact with downed lines.

5. Immediately clean up spills according to facility procedure.

6. Use the telephone only for genuine emergency calls.

VI. Hemorrhage - If client falls and cuts himself/herself and is bleeding in large amounts, follow these steps: **(II-8)**

A. Call for help as you go to the client.

B. Apply firm pressure with gloved hand to the bleeding area.

C. Stay with client until more help comes.

D. If the injury is to an arm or leg, and you can move the arm or leg without causing further injury, raise the bleeding site above heart level to slow down the blood coming to the area.

E. If the client is standing up, assist her/him to lie on a bed, couch, or on the floor so she/he does not faint from blood loss and fall to the floor.

F. Do not apply a tourniquet.

G. Follow directions given by the charge nurse.

VII. Falls **(II-9)**

A. If client falls while he/she is unattended:

1. Call for help immediately.

2. Do not move client until the charge nurse has assessed injuries. Some injuries may require that the client remain on the floor until paramedics arrive. Be calm, let the client know help is on the way. Stay with the client.

3. Check for swelling, bruising, position change of any extremities, complaint of pain, and promptly report to charge nurse.

4. Assist charge nurse by checking vital signs.

5. Assist charge nurse in moving client--may need as many as four or five people, depending on the size of the client and location of injury. Support client and hold securely when moving.

B. If client falls while attended by a health care assistant: (HO 2)

1. Do not try to prevent the fall, do try to prevent injury.

2. Use your body in the following steps: **(II-9)**

a. Remember body mechanics - feet apart, back straight

b. Pull client close to you - hold on to him/her using gait belt or by wrapping your arms around his/her waist.

c. Lean the client onto your leg as you go down to the floor with him/her.

d. Gently lower yourself and the client to the floor, keeping your back straight.

e. Prevent the client's head from hitting the floor.

f. Call for help immediately.

g. Do not move the client until examined by charge nurse.

VIII. Seizures

A. A seizure is a convulsion - sudden, periodic attacks of muscles contracting and relaxing.

B. Follow these steps if you think a client is having a seizure.

  1. Clear the area around the client of anything hard or sharp.

  2. Loosen anything around his/her neck that may make breathing difficult.

  3. Put something flat and soft under his/her head.

  4. Turn the client gently on his/her side--helps keep airway clear. Do not try to force his/her mouth open with any hard object or with your fingers. A person having a seizure cannot swallow his/her tongue, and efforts to hold his/her tongue down can injure the teeth or jaw.

  5. Do not hold the client down or try to stop his/her movements.

  6. Stay with the client until the seizure has ended.

  7. Observe, note, and report the following: **(II-10)**

    a. Time seizure started and how long it lasted

    b. If the seizure started at a certain area of the body or was generalized from the start

    c. If the client was incontinent

IX. Choking **(II-11)**

A. Cause in elderly

  1. Elderly are more prone to choking due to weakened muscles of the mouth and throat.

  2. Food, saliva, or medication can cause a blockage of the respiratory tract.

  3. Improperly fitting dentures or no dentures can make chewing difficult. Large pieces of food can easily slip down the throat.

  4. Following a stroke there may be diminished gag and swallowing reflexes.

B. Take the following precautions to avoid choking when feeding a client:

  1. Cut food in small pieces.

2. Do not rush client; allow him/her time to chew the food thoroughly and swallow it before giving more.

3. Make sure dentures are in place and fit well.

C. If choking occurs:

1. Act quickly.

2. Start Heimlich maneuver.

3. In recent years, the Heimlich maneuver included the use of back blows when partial or complete airway obstruction was present.

    a. It is no longer recommended for children or adults when complete airway obstruction is present.

    b. Only recommended for infants who can be placed in the head down position.

D. Assess if there is obstruction.

1. Ask client if he/she is choking.

2. Ask client if he/she can speak.

3. Tilting the head back can sometimes clear the airway. This position pulls the tongue forward.

4. If the client can speak or is coughing, do not intervene.

    a. Coughing is the most effective way to dislodge material from the airway.

    b. Stay close and encourage coughing.

    c. Starting the Heimlich maneuver at this point may cause him/her to breathe in harder and force the object further down in the respiratory tract.

    d. If at any point the client develops difficulty breathing or is unable to cough or speak, start the Heimlich maneuver.

    e. The Heimlich maneuver is usually sufficient to "pop" the obstructing object out of the client's airway. The maneuver forces air out of the lungs pushing the object out with it.

X. Cardiopulmonary Resuscitation - CPR

A. A life saving procedure.

B. Given when a person's heart suddenly stops.

C. Technique must be taught by a certified instructor.

D. The following are important parts of the procedure. They DO NOT replace the course.

1. Shout, "are you all right" as you shake the victim.

2. Turn victim on back.

3. Open airway - observe for breathing.

4. Use mouth-to-mouth breathing using appropriate device. Give two full breaths.

5. Feel for carotid pulse.

6. Begin chest compression if there is no pulse.

7. Knell beside victim's shoulders.

8. Position hands.

a. Place heel of right hand over lower portion of breastbone.

CAUTION: Do not place heel of hand on tip of breast bone or over ribs.

b. Place left hand over right hand.

c. Keep elbows straight.

d. Compress breastbone downward.

e. Continue compressions at a rate of 60 per minute. If only one person is doing CPR, do 15 compressions to 2 breaths per minute.

XI. Demonstrate Procedures for Clearing Airway of Obstruction and Performing CPR. (HO 3) **(II-12 - 19)**

XII. Summary and Conclusion

A. Terms and definitions

B. Fire prevention

C. In case of fire

D. Tornado safety

E. Earthquake safety

F. Hemorrhage

G. Falls

H. Seizures

I. Choking

J. Cardiopulmonary resuscitation - CPR

K. Review procedures for clearing airway of obstruction and performing CPR.

This information is fresh in your mind, and you would probably be able to respond appropriately and quickly if faced with any of the situations mentioned. It is important, though, for you to review this lesson plan periodically because in six months to a year from now it will not be as fresh in your mind. To perform in a safe manner you must be acquainted with the proper way of handling all of these situations. The next lesson is on body mechanics.

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

STEPS OF PROCEDURE FOR CLEARING AIRWAY OBSTRUCTION IN CONSCIOUS CLIENT:

1. Call for help as you approach the client.

2. Tell the client you are going to help.

3. Position yourself behind the client if the client is standing or sitting.

4. Slide your arms under client's arms, wrapping both of your arms around client's waist.

5. Make a fist and place thumb side of this fist against the midline of the client's abdomen, just above the navel.

   NOTE: Keep your fist below the client's rib cage, and avoid the area just below the sternum.

6. Grasp your fist with free hand.

7. Apply pressure as an inward and upward thrust.

8. Deliver six to ten inward and upward thrusts.

9. Continue until obstruction is cleared or medical support arrives.

STEPS OF PROCEDURE FOR CLEARING AIRWAY OBSTRUCTION IN UNCONSCIOUS CLIENT:

1. Call for help as you approach client.

2. Check for unresponsiveness and no breathing.

3. Turn client on back.

4. Put on gloves.

5. Open airway by tipping head back and lifting jaw. Look, listen, and feel for breathing.

6. Insert mouthpiece. Attempt breathing. (1 breath every 5 seconds)

7. Re-open airway.

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8. Insert mouthpiece. Attempt breathing.

9. Provide abdominal thrust (Heimlich maneuver) 6 to 10 times.

   a. Straddle client at the level of the hips.

   b. Position the heel of one hand on the client's abdomen at the midline, between the navel and rib cage.

      NOTE: Fingers should point toward the client's chest.

   c. Keep hands below client's rib cage avoiding the area just below the sternum.

   d. Place free hand over the positioned hand and put your shoulders directly over the client's abdomen.

   e. Press hands inward and toward client's diaphragm, as if you are trying to push toward the client's upper back.

10. Check for foreign object.

    a. With face up, open mouth and grasp tongue and jaw between thumb and index finger. Draw tongue forward. Do not let mouth close.

    b. Insert index finger of other hand down along side of cheek toward the base of the tongue.

    c. Sweep around mouth. Bend finger into a hook and attempt to bring foreign object up into the mouth if you can see it.

    CAUTION: Do not force object further into the throat.

    d. If possible, remove object from mouth.

11. Re-open airway. Insert mouthpiece. Attempt breathing.

12. Repeat procedures until airway is cleared and life support is available.

13. Remove gloves and dispose in appropriate container. Wash hands.

STEPS OF PROCEDURE FOR PERFORMING CPR:

NOTE: The instructor can only instruct CPR if he/she is a certified CPR instructor. Check with your local American Heart Association or Red Cross for more information.

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

INTERACTION ITEMS:

1. What are the definitions of seizure, unconscious, supine, hemorrhage, ventilate, obese, extremities, and obstruction?

2. What are some things that may cause a fire in the facility?

3. What is the first thing you do when you find a fire?

4. Whom do you evacuate first?

5. What is the difference between tornado watch and warning?

6. Have any of you ever been in a tornado? What was it like?

7. If you are in the facility during an earthquake, where would be a good place to take cover?

8. Why don't you apply a tourniquet?

9. What do you do if a client begins to fall while attended by you, the health care assistant?

10. What observations should be made during a seizure?

11. What are some things you do to help prevent choking while feeding a client?

12. Why don't you do abdominal thrusts on someone who can speak, cough, or breathe?

13. Why do you act immediately when the person cannot speak?

14. How do you hold the hands to do the abdominal thrusts?

15. When does the procedure stop?

16. What is the first step for clearing the airway in the conscious victim?

17. What is the first step for clearing the airway in the unconscious victim?

18. What is cardiopulmonary resuscitation?

19. What is the procedure for performing CPR?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students demonstrate how to remove a bedridden client during a fire.
2. Have students locate fire alarms, extinguishers, and exits in the facility.
3. Demonstrate proper use of fire extinguishers.
4. Show films.
5. Have students practice falling with another student (one as the health care assistant and the other as the client).
6. Instructor should demonstrate clearing airway obstruction in the conscious client.
7. Students should perform the procedure clearing airway obstruction in the conscious client.
8. Instructor should demonstrate clearing airway obstruction in the unconscious client.
9. Students should perform the procedure clearing airway obstruction in the unconscious client.
10. Class discussion of the following situation. You enter Mrs. Taft's room. There are some flames shooting up from a wastebasket, and they are igniting the bedspread. Mrs. Taft is in the bathroom. What steps will you take?
11. Class discussion of the following situation. You enter the room of Mr. Harris. You find him lying on the floor beside his bed. He is crying. What will you do?
12. Have students locate the rib cage and sternum on the anatomy diagram.
13. Have a certified CPR instructor demonstrate cardiopulmonary resuscitation.

ANSWERS TO EVALUATION ITEMS:

1. e
2. g
3. d
4. c
5. b
6. f
7. a
8. h
9. d
10. b
11. d
12. b
13. a

14. watch
15. warning
16. b
17. c
18. d
19. b

20. Time it started and how long it lasted. If seizure started at a certain area of the body or was generalized from the start. If the client was incontinent.

21. a
22. c
23. d

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

EVALUATION ITEMS:

Match the following terms in Column I to the correct definitions in Column II.

	Column I		**Column II**
____ 1.	Seizure	a.	The arms, legs, hands, and feet
____ 2.	Unconscious	b.	Give air to
____ 3.	Supine	c.	Excessive uncontrolled bleeding
____ 4.	Hemorrhage	d.	Lying on one's back
____ 5.	Ventilate	e.	Sudden, periodic attacks of muscles, contracting and relaxing
____ 6.	Obese	f.	Extremely fat
____ 7.	Extremities	g.	An individual's lacking in awareness
____ 8.	Obstruction	h.	A blockage

9. Which of the following is not a fire prevention safety point? (Circle the letter of the best answer.)

   a. Never empty ashtrays into any container which may contain flammable fluids.
   b. Allow smoking only under supervision and in approved areas.
   c. Know the location of fire extinguishers and how to use each type.
   d. Prop open fire door with a chair.

10. In case of a fire, which one of the following should you do first? (Circle the letter of the best answer.)

    a. Call for the charge nurse.
    b. Remove clients in danger.
    c. Call the fire department.
    d. Call Dr. Red over the loudspeaker.

11. As you leave a room where there is a fire, you: (Circle the letter of the best answer.)

    a. Close the windows
    b. Leave the door open
    c. Open the windows
    d. Close the door

12. The number one cause of fires in health care institutions is from: (Circle the letter of the best answer.)

    a. Faulty wiring
    b. Smoking
    c. Too many things plugged into one outlet
    d. Using flammable liquids around gas (from dryers, hot water heaters)

13. During a fire, when evacuating clients you should: (Circle the letter of the best answer.)

    a. Remove ambulatory clients first
    b. Remove wheelchair clients first
    c. Remove bedridden clients first
    d. Remove the client nearest you first

14. A tornado ________________ is announced when conditions are such that a tornado may develop.

15. A tornado ________________ occurs when a tornado has been identified within the local area of a community.

16. When a tornado alarm is sounded you should: (Circle the letter of the best answer.)

    a. Clear all dining and activity rooms of staff.
    b. Move clients into hallway near exits or into closets.
    c. Open all windows and fire doors.
    d. Get all clients back to bed.

17. During an earthquake you should: (Circle the letter of the best answer.)

    a. Move bed clients into the hallway.
    b. Move bed clients under the bed.
    c. Stay calm and stay where you are until the earthquake movement ceases.
    d. Close all doors and windows to lessen flying debris.

18. Which one of the following is a correct step to control hemorrhage from a cut? (Circle the letter of the best answer.)

    a. Run to the nurses station for the charge nurse
    b. Apply a tourniquet immediately
    c. If the cut is to an arm or leg, lower the bleeding site below heart level
    d. Apply firm pressure with a gloved hand to the bleeding area

19. If the client begins to fall while you are walking with him/her, you should: (Circle the letter of the best answer.)

    a. Get a blanket for the client immediately
    b. Very gently ease the client to the floor
    c. Call for a co-worker to bring you a pillow
    d. Leave the client to get help

20. List three observations to make if a client is having a seizure.

    a.

    b.

    c.

21. Thrusts are not done when giving first aid to a choking victim who can speak, cough, or breathe because: (Circle the letter of the best answer.)

    a. It would force the victim to breathe in harder and force the object further down the respiratory tract.
    b. It would force the victim to "pop" the object out of their respiratory tract.
    c. It would force the victim to exhale.
    d. It would force the victim to vomit and force the object further down the respiratory tract.

22. To avoid choking when feeding a client, do all of the following except: (Circle the letter of the best answer.)

    a. Cut food in small pieces.
    b. Give manageable amounts of food at a time.
    c. Don't bother putting dentures in.
    d. Allow the client time to chew and swallow the food.

23. When performing cardiopulmonary resuscitation (CPR) you should: (Circle the letter of the best answer.)

    a. Turn the victim on his/her stomach.
    b. Feel for the radial pulse.
    c. Place heel of left hand on tip of breastbone.
    d. Place heel of right hand over lower portion of breastbone.

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

EVALUATION ITEMS: NAME OF STUDENT: ______________

CLEAR AIRWAY OBSTRUCTION IN CONSCIOUS CLIENT

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Call for help as you approach the client.		
2. Tell the client you are going to help.		
3. Position yourself behind the client if the client is standing or sitting.		
4. Slide your arms under client's arms, wrapping both of your arms around client's waist.		
5. Make a fist and place thumb side of this fist against the midline of the client's abdomen, just above the navel.		
6. Grasp your fist with free hand.		
7. Apply pressure as an inward and upward thrust.		
8. Deliver six to ten inward and upward thrusts (Heimlich Maneuvers).		
10. Continue until obstruction is cleared or medical support arrives.		

The student has satisfactorily completed the procedure "CLEAR AIRWAY OBSTRUCTION IN CONSCIOUS CLIENT" according to the steps outlined.

______________________________ ______________

Instructor's/ Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 10

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

EVALUATION ITEMS: NAME OF STUDENT: ______________

CLEAR AIRWAY OBSTRUCTION IN UNCONSCIOUS CLIENT

EQUIPMENT:

1. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Call for help as you approach client.		
2. Check for unresponsiveness.		
3. Turn client on back.		
4. Put on gloves.		
5. Open the airway by tipping head back and lifting jaw. Look, listen, and feel for breathing.		
6. Insert mouthpiece. Attempt breathing. (1 breath every 5 seconds)		
7. Re-open airway.		
8. Insert mouthpiece. Attempt breathing.		
9. Provide abdominal thrusts (Heimlich Maneuver) 6 to 10 times. a. Straddle client at the level of the hips.		
b. Position the heel of one hand on the client's abdomen at the midline, between the navel and rib cage.		
c. Keep hands below client's rib cage avoiding the area just below the sternum.		
d. Place free hand over the positioned hand and put your shoulders directly over the client's abdomen.		
e. Press hands inward and toward client's diaphragm, as if you are trying to push toward the client's upper back.		
10. Check for foreign object. a. With face up, open mouth and grasp tongue and jaw between thumb and index finger. Draw tongue forward. Do not let mouth close.		
b. Insert index finger of other hand down along side of cheek toward the base of the tongue.		

	c. Sweep around mouth. Bend finger into a hook and attempt to bring foreign object up into the mouth if you can see it. CAUTION: Do not force object further into the throat.		
	d. If possible, remove object from mouth.		
11.	Re-open airway. Insert mouthpiece. Attempt breathing.		
12.	Repeat procedures until airway is cleared and life support is available.		
13.	Remove gloves and dispose in appropriate container. Wash hands.		

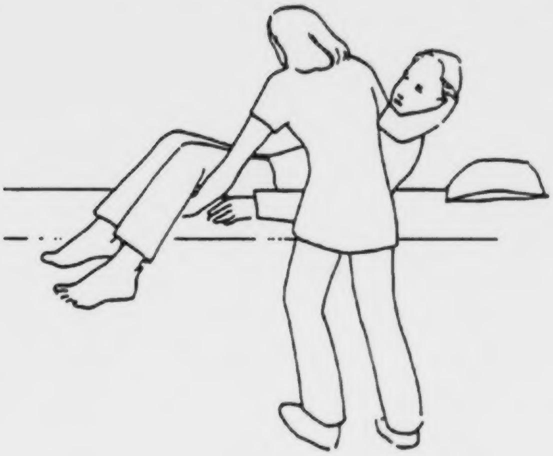
The student has satisfactorily completed the procedure "CLEAR AIRWAY OBSTRUCTION IN UNCONSCIOUS CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

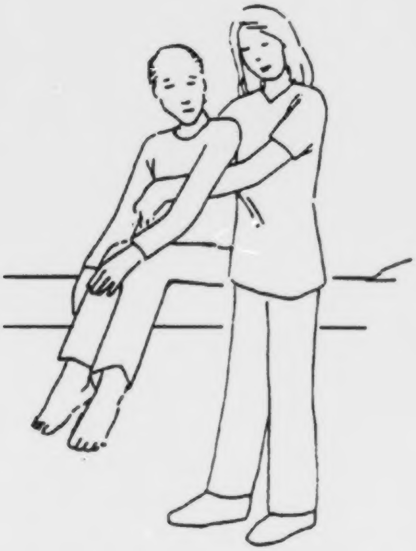
Date

HO 1

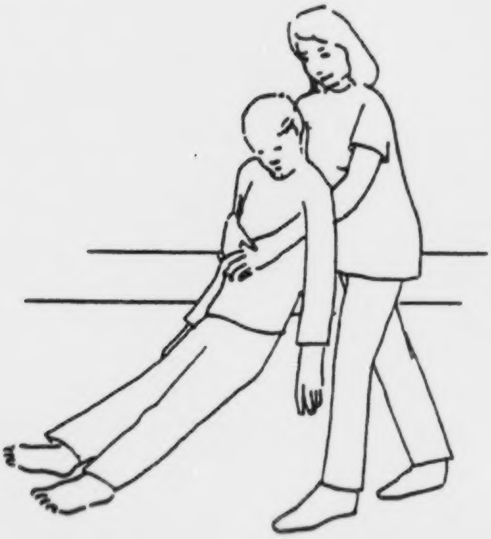
MOVING CLIENT TO SAFETY



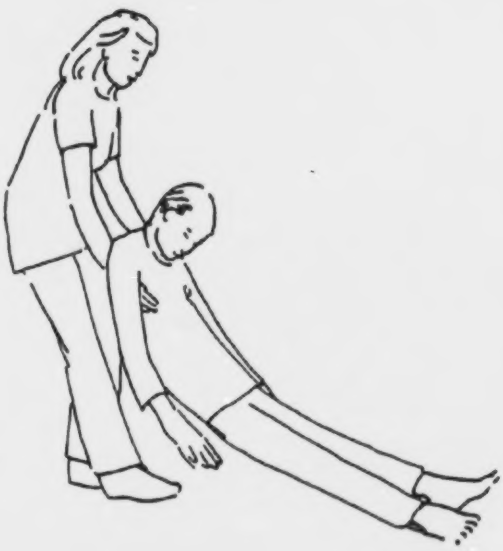
1. Lift client to a sitting position, legs over side of bed.



2. Grasp client from behind, under arms.



3. Slide client from bed, lower to floor.

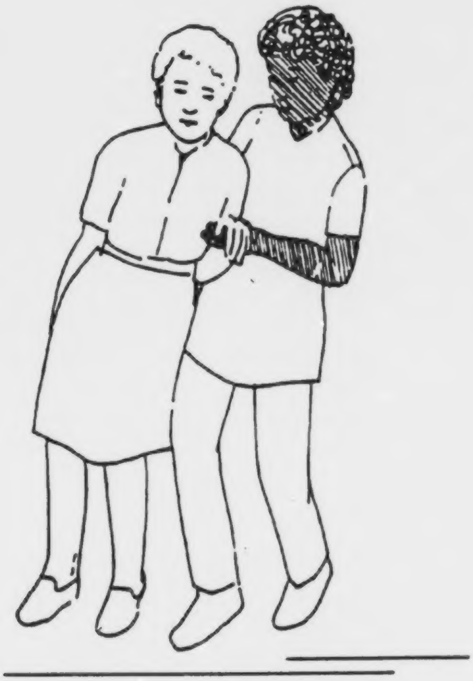


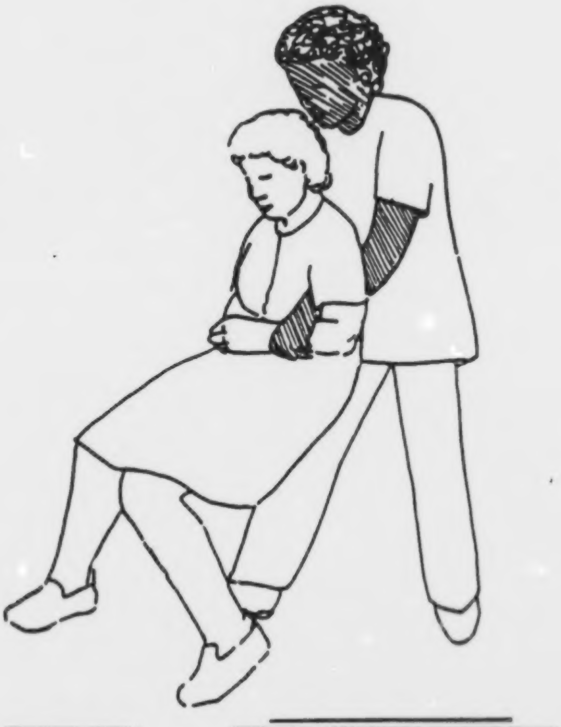
4. Drag from room, hands under shoulders at arms. If conditions permit, roll client onto blanket, then drag from room.

HO 2

SAFELY HANDLING A FALLING CLIENT

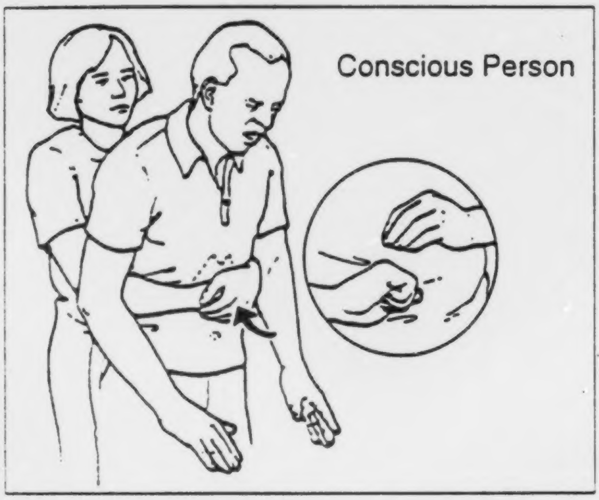
When handling a falling client, pull him/her close to your body and gently ease him/her to the floor.



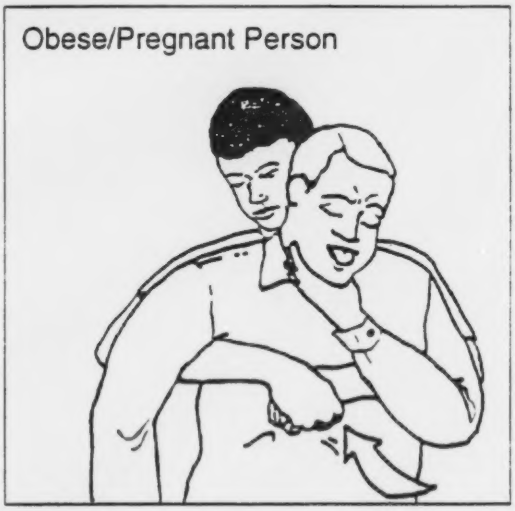


FIRST AID FOR THE CHOKING VICTIM (ADULT)

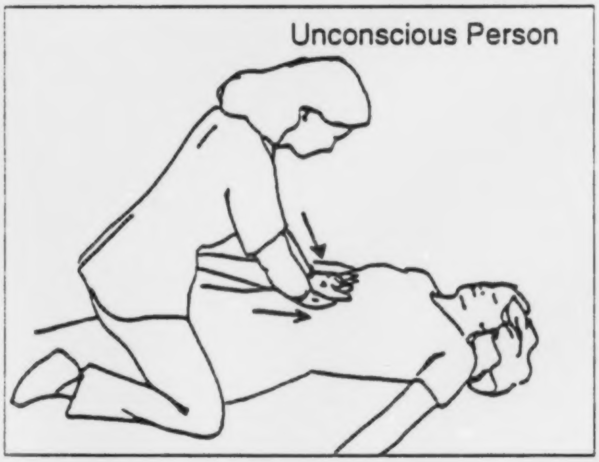
ABDOMINAL THRUSTS



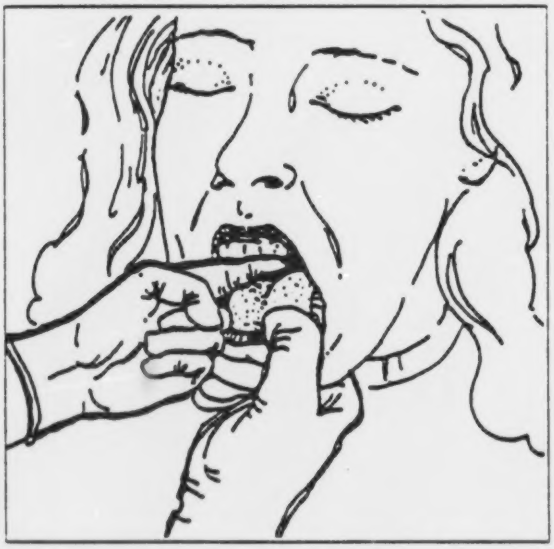
Conscious Person



Obese/Pregnant Person



Unconscious Person



MOUTH SWEEP

LESSON PLAN: 11

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the health care assistant in fire and disaster safety and using body mechanics to position the client. It is vital to our clients' and our own well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: III-11 AND DEMONSTRATION: III-11

BODY MECHANICS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Define body mechanics.
2. Identify five reasons body mechanics are important.
3. Identify key points of body mechanics.
4. Describe the seven body positions for clients.
5. Identify principles of lifting and moving a client.

Demonstration

6. Position client in the seven body positions.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Key Points in Body Mechanics
2. HO 2: Body Positions
3. HO 3: Bed Positioning for the Hemiplegic Client
4. Bed with side rails
5. Two pillows - additional blankets/towels as needed

6. Handroll/washcloth

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 11 (Student Reference page 189) prior to class and be prepared to discuss the information presented and return the demonstration on positioning clients.

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INTRODUCTION:

As a health care assistant, one of your duties will be to move clients. You must know how to do this without straining your back and causing an injury to yourself or the client. There are ways to use your body to reduce strain and fatigue and that is what this lesson will cover. Remember, your feet are your base of support. Your strongest and largest muscles are in the shoulders, upper arms, hips, and thighs. These are the muscles which we use to lift and move heavy objects.

Correct positioning of the incapacitated client is very important. Proper positioning can prevent complications of decubitus ulcers (bedsores) or contractures of a muscle. This lesson will include ways to position the client.

Clients will often need help when moving in the bed. You must assess your client properly to determine if you can move him/her by yourself or if you will need help. If the procedure requires two persons due to the client being "dead weight," very heavy, or one with very fragile skin, use a pull/lift sheet. This will prevent friction and irritation to the skin. Keep in mind the principles of body mechanics anytime you are moving the client.

Proper positioning of the client in the bed is necessary to maintain normal body function, to prevent contractures, to assure comfort, and to prevent pressure on one area of the body. Body alignment is the proper relationship of body parts to each other to avoid unnecessary strain/injury. Always look at the client when positioning him/her to see if the body is straight and looks comfortable; check to make sure no bony areas are pressing/rubbing on the mattress. Pillows are used to position the client. If you do not have enough pillows, a rolled bath blanket may be used.

LESSON PLAN: 11

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

OUTLINE:

I. Body Mechanics - using correct movement of the body in performing certain functions in a manner that does not add undue strain. **(II-1)**

II. Importance of Body Mechanics **(II-2)**

- A. Protects you from injury by aligning body segments to each other; by standing straight, the main parts of your body (head, chest, and pelvis) are properly aligned one over the other to maintain good balance
- B. Reduces fatigue to prevent strain on the spine
- C. Makes the spine work with you and for you to maximize body strength
- D. Makes lifting, transferring, and moving objects easier to minimize fatigue
- E. Provides balance and stability
- F. Using proper body mechanics is the safest thing you can do to prevent injury to yourself and the client.

III. Key Points of Body Mechanics (HO 1)

- A. When moving a client, be sure he/she knows when he/she is going to be lifted, how you plan to do it, and where you are going to lift him/her to. Use verbal cues.
- B. Determine what has to be done and if you will need help. Never attempt to lift alone if you feel that you will not be able to do so safely.
- C. Place feet apart (about 12-14 inches) with one slightly ahead of the other. Feet should be shoulder-width apart to give you a broad base of support (i.e., area on which your weight is resting). Keep your weight evenly balanced on both feet. **(II-3)**
- D. Get close to whatever is being lifted, instead of reaching for it. Move in and hold the object close to your body.
- E. Keep your back straight; bend at the hip and knees. **(II-4)**
- F. To lift, squat or bend knees, then straighten your legs. Using your thigh or leg muscles, lift the object with your upper arms.

G. Lift smoothly to avoid strain produced by jerky movements. Use verbal cues to signal your coworker when it is time to lift; i.e., count, "one, two, three, LIFT!" **(II-5)**

H. When changing the direction of your body, pivot with your feet--never twist your body.

I. Push, pull, slide, and roll whenever possible, rather than lift.

J. Remind coworkers to use good body mechanics.

K. Use your arms to support an object. The muscles of your legs actually do the job of lifting, not the muscles of your back.

L. Always look for any obstacles or hazards before moving a client.

M. When an action requires physical effort, try to use as many muscles as possible. For example, use both hands rather than one hand to pick up a heavy piece of equipment.

N. When you lift an object or need to pick something up off the floor, squatting down rather than bending over will reduce strain on the spine. **(II-6)**

O. Ambulatory clients should observe the same body mechanics as a health care assistant.

P. Incapacitated clients who cannot change their positions

1. Get help as needed.
2. Use turning and lifting sheets.
3. Use mechanical devices.
4. Change their positions at least every two hours.

Q. Support natural body curves in their normal positions.

1. Client feels more comfortable.
2. It relieves strain on the body.
3. Proper body position assists the body in functioning properly.
4. Proper positioning prevents contractures and pressure areas.

IV. Seven (7) positions for the Incapacitated Client (HOs 2 & 3)

A. Supine - also called back lying, dorsal recumbent, or horizontal recumbent

B. Right lateral recumbent position - on the right side with the spine straight

C. Prone position - on the abdomen with the spine straight

D. Left lateral recumbent position - on the left side with the spine straight

E. On the back with the head of the bed elevated

  1. Semi Fowler's - head of bed elevated 30°

  2. Fowler's - head of the bed elevated 45° to 60°

  3. High Fowler's - the head of bed elevated 90°

F. Sims' position - on the left side, with the left leg extended and the right leg flexed

G. Sitting position - sitting with head and spine erect

V. Principles to Remember when Lifting and Moving a Client

A. The health care assistant's movements should be slow and steady.

B. Explain to the client what you are going to do so that he/she will have confidence in you.

C. Allowing a client to stay in a fetal position (curled-up position) can lead to decubitus, pneumonia, contractures, bloods clots, and kidney and bladder stones.

D. Change the client's position at a minimum of every 2 hours.

E. Always lift the client, NEVER slide him/her. A lift sheet can be used to help lift the client which helps prevent friction on the skin. **(II-6)**

F. Sliding causes the client's skin to rub against the sheets which can scratch and injure the skin.

G. Handle the client gently. Remember skin is easily bruised and bones are easily broken.

H. Sitting up in bed may cause the client to become dizzy.

I. When moving a client protect all tubing.

J. If the client is able to assist with moving, direct the client what to do and when to do it. For example, the health care assistant instructs the client to bend knees and place feet firmly on bed. On the count of three, the client pushes with his/her feet as the health care assistant moves the client up in the bed. **(II-7)**

K. When working with another health care assistant to move/lift a client, the health care assistants work on opposite sides of the bed. Movements should be synchronized as the client is moved/lifted. **(II-8, 9)**

L. Always wash hands between clients.

VI. Demonstrate Procedures for Positioning Clients

VII. Summary and Conclusion

A. Body mechanics

B. Importance of body mechanics

C. Key points of body mechanics

D. Seven positions for the incapacitated client

E. Principles to remember when lifting and moving a client

F. Review procedures for positioning clients

The importance of understanding and using proper body mechanics cannot be overemphasized. Serious injury to either or both the health care assistant and client can occur as a result of improper lifting or moving techniques. The next unit is on concepts of microbiology.

LESSON PLAN: 11

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

STEPS OF PROCEDURE FOR POSITIONING CLIENT IN SEVEN BODY POSITIONS.

(II-10 - 12)

Wash hands; provide privacy for all positions.

Tell client what you are going to do.

Prone position

1. Position client on abdomen.
2. Straighten spine.
3. Straighten legs.
4. Flex arms and bring up on either side of the head.
5. Place a small pillow under the abdomen.
6. Place a small pillow under the lower legs and ankles.
7. An alternate method may be used by moving the client to the foot of the bed and extending the feet over the edge of the mattress.

Left lateral recumbent position

1. Position client on left side.
2. Place pillow under head.
3. Flex right leg.
4. Support right leg with a pillow.
5. Place a pillow in front of client to extend under the flexed right arm and shoulder.
6. Flex the left arm and bring it up under the head pillow.

Fowler's position

1. Position client on back.
2. Elevate head of bed.

    - a. Semi-Fowler's 30°
    - b. Fowler's 45°-90°
    - c. High Fowler's 90°

3. Place a pillow under each arm.
4. May use padded footboard to prevent foot drop.

Sims' position

1. Position client on left side.
2. Extend left leg.
3. Flex right leg.
4. Extend left arm and place it behind the back.
5. Place a small pillow under head.

Sitting position

1. Place client in chair so that the head and spine are erect.
2. Position back and buttocks against the back of the chair.
3. Place a small pillow at the small of the back.
4. Position the legs so that the back of the knees are forward so as to not touch the chair.

Supine position

1. Place bed in flat (horizontal) position.
2. Position client on the back.
3. Place a pillow under client's head.
4. Extend arms and support with small pillows.
5. Support small of back with a rolled towel.
6. Place a small pillow or rolled towel along the thigh and tucked under to prevent the hip from rotating outward.
7. May use a padded foot board to prevent foot drop.

Right lateral recumbent position

1. Turn client on right side with spine straight.
2. Flex right arm and position under the pillow.
3. Bring left arm straight over the hip.
4. Flex left leg slightly and support it on a pillow.

Wash hands.

Position call light.

LESSON PLAN: 11

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

INTERACTION ITEMS:

1. How do you define body mechanics?
2. What are five reasons why body mechanics are important?
3. How should your feet be placed in order to provide a broad base of support?
4. What is the position of the back, hips, and knees when lifting an object?
5. How can you signal your coworkers that you are ready to move a client?
6. How do you lift or pick something up off the floor?
7. What are the seven positions for positioning a client?
8. How do you instruct clients who are able to assist when lifting and moving them up in bed?
9. Where does the second person stand when two persons are lifting a helpless client?
10. What can be the result of failing to synchronize with verbal cues when two persons are working together in a lifting procedure?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisual.
2. Have each student lift box off floor using proper body mechanics.
3. Show anatomy diagram of muscle groups used when lifting.
4. Have a class discussion on good posture.
5. Have the class see how long they can balance on one foot.
6. Have students position each other in the seven positions for positioning a client.

ANSWERS TO EVALUATION ITEMS:

1. Using correct movements of the body in performing certain functions in a manner that does not add undue strain.

2. b
3. d
4. b
5. a
6. b
7. d
8. c
9. e
10. a
11. g
12. d
13. b
14. d

LESSON PLAN: 11

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

EVALUATION ITEMS:

1. Define body mechanics.

2. Using good body mechanics does all of the following except: (Circle the letter of the best answer.)

   a. Prevents injury to the client.
   b. Increases the client's strength.
   c. Prevents injury to the health care assistant.
   d. Makes lifting and moving object easier.

3. Proper body mechanics includes: (Circle the letter of the best answer.)

   a. Straightening the knees and hips while moving an object.
   b. Placing feet together, side by side.
   c. Lifting objects using the muscles of your back.
   d. Placing feet shoulder width apart to give broad base of support.

4. The largest and strongest muscles are located in the: (Circle the letter of the best answer.)

   a. Neck and chest.
   b. Hips and thighs.
   c. Back and neck.
   d. Feet and legs.

5. When carrying a heavy object, you should carry it: (Circle the letter of the best answer.)

   a. Close to your body.
   b. At arms length.
   c. Just above your head.
   d. Below the waist line.

6. To lift a heavy object from the floor, you should: (Circle the letter of the best answer.)

   a. Bend from the waist.
   b. Squat on the floor.
   c. Kneel on the floor.
   d. Keep your knees straight.

7. The correct way to change the direction of your body is: (Circle the letter of the best answer.)

   a. Turn backwards.
   b. Turn your body in segments.
   c. Turn from the waist.
   d. Turn your entire body.

Match the position in Column I with the correct description of the position in Column II.

Column I

____ 8. Sims'

____ 9. Sitting

____ 10. Supine

____ 11. Prone

____ 12. Fowler's

____ 13. Left lateral recumbent

Column II

a. On the back

b. On the left side with the spine straight

c. On the left side with the left leg extended and the right leg flexed

d. On the back with head of bed elevated

e. Sitting with head and spine erect

f. On the right side with the spine straight

g. On the abdomen with spine straight

14. When lifting and moving the client, the health care assistant should: (Circle the letter of the best answer.)

   a. Always slide the client from one side of the bed to the other side.
   b. Move fast.
   c. Allow the client to remain in the fetal position.
   d. Change the client position at a minimum of every two hours.

LESSON PLAN: 11

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT III : SAFETY

EVALUATION ITEMS: NAME OF STUDENT: ______________

POSITION CLIENT IN SEVEN BODY-POSITIONS

EQUIPMENT:

1. Pillows

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
Wash hands; provide privacy for all positions.		
Tell client what you are going to do.		
Prone position 1. Position client on abdomen.		
2. Straighten spine.		
3. Straighten legs.		
4. Flex arms and bring up on either side of the head.		
5. Place a small pillow under the abdomen.		
6. Place a small pillow under the lower legs and ankles.		
7. An alternate method may be used by moving the client to the foot of the bed and extending the feet over the edge of the mattress.		
Left lateral recumbent position 1. Position client on left side.		
2. Place pillow under head.		
3. Flex right leg.		
4. Support right leg with a pillow.		
5. Place a pillow in front of client to extend under the flexed right arm and shoulder.		
6. Flex the left arm and bring it up under the head pillow.		
Fowler's position 1. Position client on back.		
2. Elevate head of bed. a. Semi-Fowler's 30°		
b. Fowler's 45°-90°		
c. High Fowler's 90°		

3. Place a pillow under each arm.		
4. May use padded footboard to prevent foot drop.		
Sims' position 1. Position client on left side.		
2. Extend left leg.		
3. Flex right leg.		
4. Extend left arm and place it behind the back.		
5. Place a small pillow under head.		
Sitting position 1. Place client in chair so that the head and spine are erect.		
2. Position back and buttocks against the back of the chair.		
3. Place a small pillow at the small of the back.		
4. Position the legs so that the back of the knees are forward so as to not touch the chair.		
Supine position 1. Place bed in flat (horizontal) position.		
2. Position client on the back.		
3. Place a pillow under client's head.		
4. Extend arms and support with small pillows.		
5. Support small of back with a rolled towel.		
6. Place a small pillow or rolled towel along the thigh and tucked under to prevent the hip from rotating outward.		
7. May use a padded foot board to prevent foot drop.		
Right lateral recumbent position 1. Turn client on right side with spine straight.		
2. Flex right arm and position under the pillow.		
3. Bring left arm straight over the hip.		
4. Flex left leg slightly and support it on a pillow.		
Wash hands.		
Position call light.		

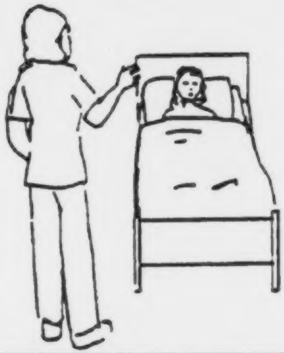
The student has satisfactorily completed the procedure "POSITION CLIENT IN SEVEN BODY POSITIONS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

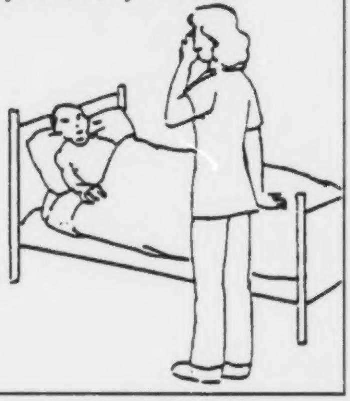
Date

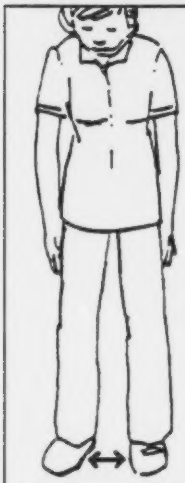
KEY POINTS IN BODY MECHANICS

1. When you are lifting a client, be sure that the client knows you are lifting, how you plan to lift, and where you are going to lift him/her to.

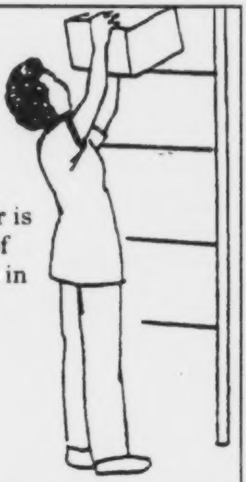


2. Size up the load to be lifted. Do not attempt to lift alone if you have any doubt about your ability to do so.

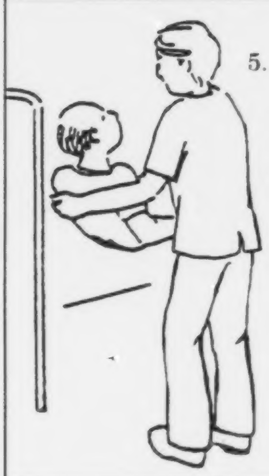




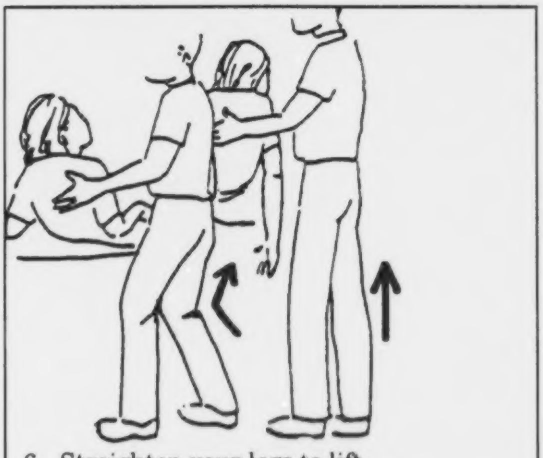
3. Check your footing. Your feet should be shoulder width apart to give you a broad base of support (good balance).



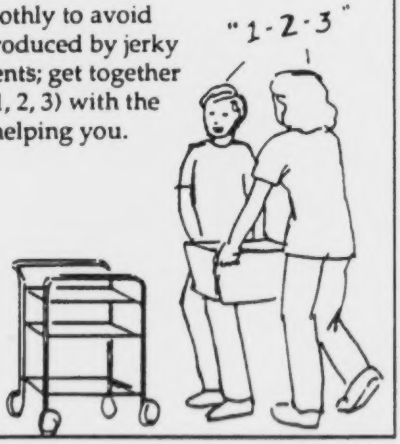
4. Get close to whatever is being lifted instead of reaching for it. Move in and hold it close.



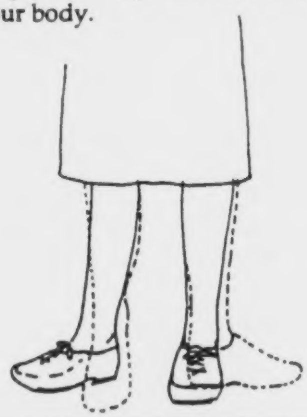
5. Get yourself "lined up," i.e., keep your back straight (put on "high midriff") bend at the knees and hips.



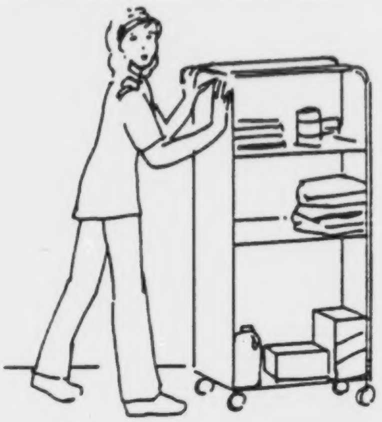
6. Straighten your legs to lift.



7. Lift smoothly to avoid strain produced by jerky movements; get together (ready, 1, 2, 3) with the person helping you.



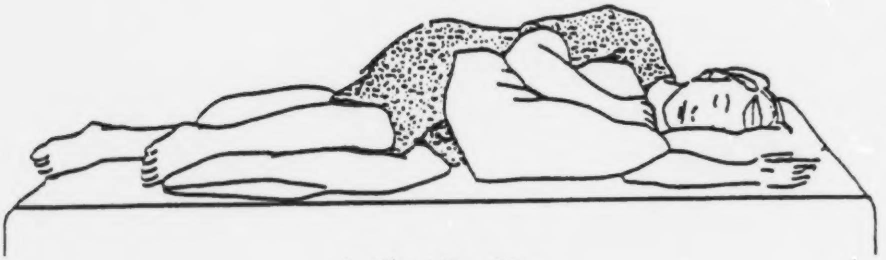
8. Shift the position of your feet to turn; never twist your body.



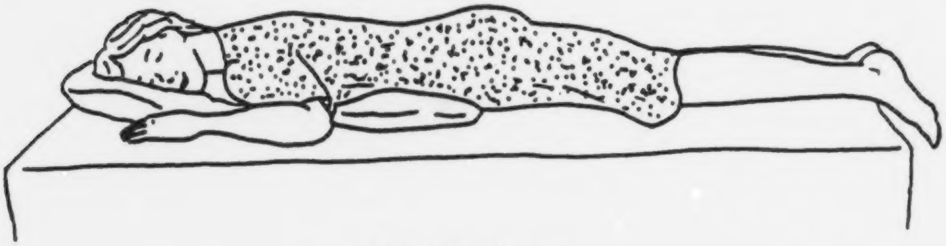
9. Push or pull an object (instead of lifting) whenever you can; and use these same rules. It is safer and easier that way.

10. Remind co-workers to use good body mechanics.

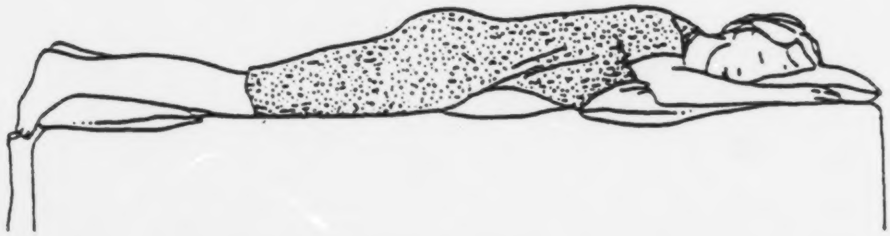
BODY POSITIONS

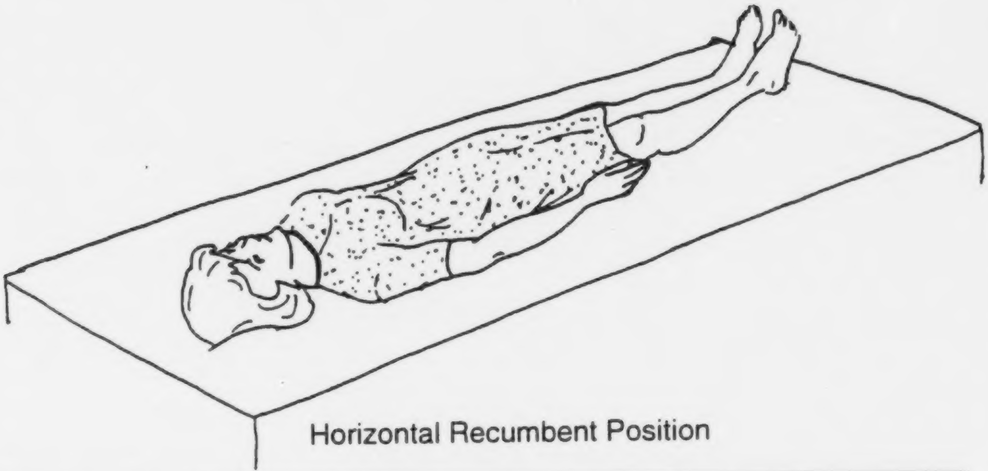


Lateral Position

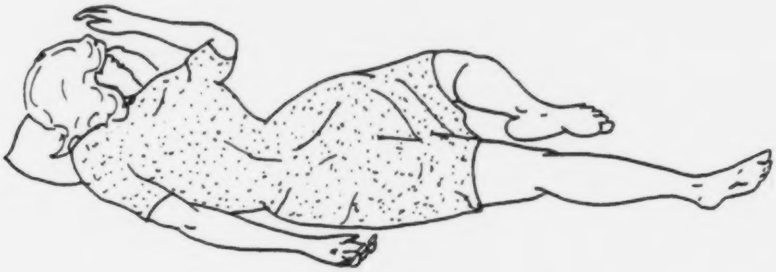


Prone Positions

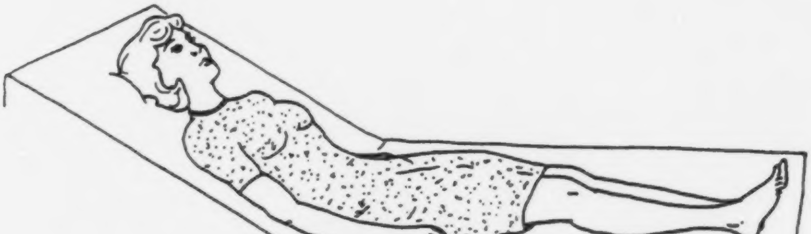




Horizontal Recumbent Position

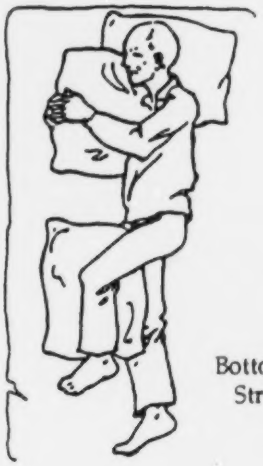


Left Sims' Position

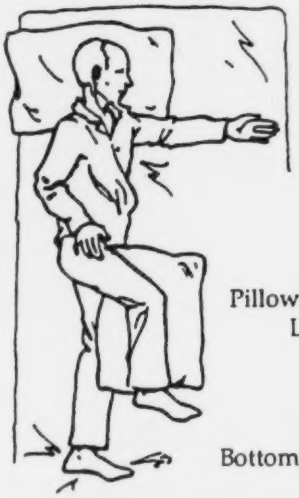


Semi Fowler's Position

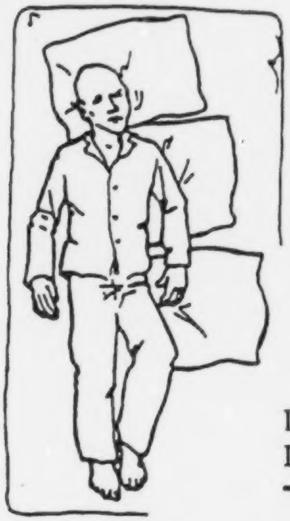
BED POSITIONING FOR THE HEMIPLEGIC CLIENT


Pillow Between Arms
Pillow Between Legs
Bottom Leg Straight

Side-Lying on Unaffected Side


Rotate Palm Toward Ceiling
Pillow Between Legs
Bottom Leg Straight

Side-Lying on Affected Side


Pillow Beneath Left Scapula
Pillow Under Left Hip

Lying on Back -
Position Weaker Side of Body

Points to Remember

- Position away from spastic patterns
- Encourage symmetrical postures
- Do not use footboards
- Promote weight-bearing on affected side
- Reposition as necessary

LESSON PLAN: 12

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

SCOPE OF UNIT:

This unit covers an introduction to microorganisms, the prevention and control of infection, isolation, AIDS, and hepatitis.

INFORMATION TOPIC: IV-12 AND DEMONSTRATION: IV-12

MICROORGANISMS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Identify terms pertaining to microorganisms by matching with their definitions.
2. Name the two classifications of microorganisms and two examples from each classification.
3. Match the types of microorganisms with the major groups.
4. Identify types of bacteria.
5. Identify methods of transmission of microorganisms.
6. Describe a sterile field.
7. Identify points to remember in sterile technique.

Demonstration

8. Open a sterile package.
9. Add sterile material to a sterile field.
10. Don sterile gloves.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Types of Bacteria
2. HO 2: Infectious Communicable Diseases

3. Carolina Biologicals, prepared slides of microorganisms
4. Sterile package
5. Sterile supplies
6. Sterile gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 12 (Student Reference page 203) prior to class and be prepared to discuss the information presented and return the demonstrations on opening a sterile package, adding sterile material to a sterile field, and donning sterile gloves.

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Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

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Kast, Barbara. Competency Exam Prep and Review for Nursing Assistants. 1st ed. Albany, NY: Delmar Publishers, 1990, Chapter 6.

INTRODUCTION:

Some microorganisms that cause fermentation in food are helpful to people. In addition, there are microorganisms in our digestive tracts that turn food into waste. Harmful microorganisms, which cause disease, are called pathogens. Pathogens give off a substance called toxins which poison the body. Pathogens also destroy body tissue because they use it as food. A good microorganism, such as those found in the digestive system, becomes pathogenic if for some reason it moves into another body system. Microorganisms can be destroyed with pasteurization, disinfection, and sterilization.

Why is it important for you to know the different kinds of microorganisms and what makes them grow and reproduce? (1) You can understand why our scientists continue to study living organisms. (2) You will have a knowledge of basic concepts which you can use to further your interest into detailed study of microbiology or related areas. (3) You will understand the necessity of eliminating disease vectors.

LESSON PLAN: 12

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

OUTLINE:

I. Terms and Definitions **(II-1)**

- A. Aerobic organism - a microorganism that requires oxygen in order to live
- B. Anaerobic organism - a microorganism that can exist only in the absence of air
- C. Autoclave - equipment used to sterilize material and equipment in a health care facility
- D. Bacteriology - study of bacteria
- E. Gram positive or gram negative bacteria - denotes color the bacteria take when a special stain is used
- F. Carrier - a person who is not infected but transports harmful pathogens
- G. Inclusion bodies - colonies of viruses growing in tissues
- H. Host - person, animal, or plant which supports a parasite
- I. Metazoa - multicellular animal forms, e.g., roundworms, tapeworms
- J. Microbiology - the scientific study of microorganisms
- K. Parasitic organism - one which uses living organic material as a source of food
- L. Pathogenic organism - one which produces disease
- M. pH - the degree to which a solution is acidic or basic
- N. Protozoa - one-celled animals
- O. Virulence - the disease-producing power of an organism
- P. Virus - smallest of all microorganisms
- Q. Sterilization - the process of destroying all microorganisms
- R. Antibiotic - a substance lethal to bacteria; drug used to destroy bacterial diseases
- S. Antiseptic - an agent which prevents infections in living tissues

T. Communicable disease - a disease which can be naturally transmitted from one individual to another by direct or indirect contact

U. Contamination - the presence of material which is capable of causing an infection

V. Disinfection - a process that destroys most pathogenic microorganisms on inanimate objects

W. Epidemiology - study of relationship of factors determining frequency and distribution of disease

X. Fomites - inanimate objects contaminated by infected persons

Y. Incubation period - period between the entrance of the organisms to the body and beginning of symptoms

Z. Medical asepsis - protection of clients and personnel from infection or reinfection (clean technique)

AA. Surgical asepsis - sterilization; total absence of bacteria from an area (sterile technique)

AB. Vector - anything animate or inanimate which carries microorganisms

AC. Infection - the entrance of living agents into tissues; these agents subsequently multiply and damage tissues

II. Classifications of Microorganisms

A. Scientific classification (II-2)

1. Plant (II-3)
2. Animal
3. Protista

B. Practical classification (II-4)

1. Pathogenic
2. Parasitic
3. Anaerobic
4. Aerobic

III. Major Groups of Microorganisms Which Cause Disease (II-5)

- A. Bacteria - single-celled microscopic plants
  - 1. Staphylococcus
  - 2. Streptococcus
- B. Fungi
  - 1. Molds - diseases, infections
    - a. Histoplasmosis
    - b. Ringworm
    - c. Athlete's foot
  - 2. Yeasts
    - a. Yeast vaginitis
    - b. Thrush
- C. Protozoa - one-celled microscopic animals
  - 1. Life cycle - some require two hosts for life cycle
  - 2. Protozoal diseases
    - a. Malaria
    - b. African sleeping sickness (African trypanosomiasis)
    - c. Amebic dysentery
    - d. Trichomoniasis (vaginal infection)
- D. Metazoa - multicellular animal forms
  - 1. Life cycle - many require two hosts
  - 2. Metazoan diseases
    - a. Pin worms
    - b. Hookworm
    - c. Trichinosis

            - d. Tape worms
    - E. Viruses - smallest of all organisms
        - 1. Size - may not be seen with microscope
        - 2. Types - many different types; affect different parts of body
    - F. Rickettsiae - classified as protista
        - 1. Transmission - usually by mosquitoes, body lice, wood ticks, and mites
        - 2. Rickettsial diseases
            - a. Rocky Mountain spotted fever
            - b. Lyme disease
            - c. Typhus fever

- IV. Types of Bacteria (HO 1) **(II-6)**
    - A. Bacillus
    - B. Spirochete
    - C. Spirillum
    - D. Diplococcus
    - E. Staphylococcus
    - F. Streptococcus
    - G. Coccus
- V. Methods of Transmission of Microorganisms **(II-7)**
    - A. Direct contact - personal contact or secretions from an infected person
    - B. Indirect contact - touching articles belonging to an infected person
    - C. Droplet spread - coughing, sneezing, talking
    - D. Vehicle - contaminated food, blood, drugs
    - E. Airborne - insects, excrement, dust particles, moisture in air
- VI. Sterile Field - an area which is free of germs and contains sterile (i.e., free of germs) materials and/or sterile equipment **(II-8)**

VII. Points to Remember in Sterile Technique

A. A sterile field is always covered with a sterile cover. This sterile cover can be the inside cover of glove wrap, a sterile sheet, or a sterile towel.

B. Keep all material and equipment two inches from the edge of the sterile field. **(II-9)**

C. Never reach over a sterile field.

D. Discard the entire sterile field if there is a suspicion that it has been contaminated. Touching with hands or clothing, coughing, or sneezing on the sterile field will make it contaminated. **(II-10)**

E. Any solution spilled on a sterile field makes it contaminated.

F. Sterile supplies are always double wrapped in paper or cloth.

G. Supplies are sealed with a seal that changes color when the supplies are sterile.

H. Hands are always held above the waist during a sterile procedure. **(II-11)**

I. Never turn your back on a sterile field.

J. Always wash your hands before applying sterile gloves and after removing them.

K. Always explain to the client what you are going to do.

L. If transfer forceps are used, don't touch the tips to anything unsterile.

M. The tips of transfer forceps must always point downward. **(II-12)**

N. When opening a sterile package, only touch the outer surface of the package. NEVER touch the inner sterile surface.

O. When adding sterile material to a sterile field, DO NOT touch the contents of the package.

P. Sterile gloves when opened correctly will be flat with the palm side up.

Q. When applying the right-hand glove, your fingers must not touch the outside of the glove.

CAUTION: Watch closely that your fingers do not extend beyond the cuff.

R. When applying the left-hand glove, only the band of the cuff may be touched with your right thumb.

CAUTION: Be alert that the right-gloved thumb does not touch your ungloved hand.

VIII. Demonstrate Procedures for Opening a Sterile Package, Adding a Sterile Material to a Sterile Field, and Donning Sterile Gloves.

IX. Summary and Conclusion

   A. Terms and definitions

   B. Classifications of microorganisms

   C. Major groups of microorganisms which cause disease

   D. Types of bacteria

   E. Methods of transmission of microorganisms

   F. Sterile field

   G. Points to remember in sterile technique

   H. Review procedures for opening a sterile package, adding sterile material to a sterile field, and donning sterile gloves

As a health care assistant you must protect yourself and the clients from the organisms we have discussed in this lesson. To master the skill of sterile technique, it will take much practice and supervision. Your next lesson will be infection control. You will learn how microorganisms spread and how to protect yourself, client, and others.

LESSON PLAN: 12

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

STEPS OF PROCEDURE FOR OPENING A STERILE PACKAGE:

1. Wash hands.
2. Check tape seal color or expiration date.
3. Place package on table with folds up.
4. Remove tape.
5. Unfold flap farthest away from you by grasping it with thumb and forefinger.
6. Open right flap with your right hand by grasping the outer surface with your thumb and forefinger.
7. Open left flap with your left hand by grasping outer surface with thumb and forefinger.
8. Touching only the outside of the flap, open flap nearest you.

STEPS OF PROCEDURE FOR ADDING STERILE MATERIAL TO A STERILE FIELD:

1. Wash hands.
2. Check tape seal color or expiration date.
3. With both hands, grasp each side of the package and pull it apart.
4. Open package.
5. Hold over sterile field.
6. Drop contents onto sterile field.

STEPS OF PROCEDURE FOR DONNING STERILE GLOVES:

1. Wash and dry hands.
2. Check glove wrap seal or expiration date.
3. Open seal.
4. Open outer cover by holding edges between the fingers and pulling in opposite directions.

5. Lift inner covering to expose the gloves.

6. If gloves are not already powdered, powder hands.

7. Discard powder packet in waste container.

8. Pick up right glove with your left hand.

9. Slip thumb of left hand inside edge of right glove at the wrist.

10. Grasp glove at edge.

11. Lift glove free of covering and table.

12. Step back a few steps.

13. Curve right hand with thumb toward your palm.

14. Using a rotating motion, pull glove on with left hand.

15. When the right glove is on, let go with your left hand.

    CAUTION: Do not pull cuff over wrist.

16. Put on left glove by holding gloved fingers of right glove together.

17. Slip gloved fingers under the cuff of the left glove.

18. Lift glove clear of table and wrapping.

19. Curve fingers of left hand with thumb slightly touching the inner aspect of your forefinger.

20. Insert left hand into glove by spreading fingers to go into the correct finger opening.

21. Adjust cuffs by slipping gloved fingers of right hand into cuff of left glove.

22. Position cuff by pushing toward arm.

LESSON PLAN: 12

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

INTERACTION ITEMS:

1. What is the definition of microbiology, pathogenic organism, parasitic organism, anaerobic organism, bacteriology, pH, metazoa, protozoa, gram positive or gram negative bacteria, inclusion bodies, virulence, host, virus, aerobic organism?
2. What are the two classifications of microorganisms?
3. What are three examples of scientific microorganisms?
4. What are four examples of practical microorganisms?
5. What are the six major groups of microorganisms?
6. What are seven types of bacteria?
7. What are the five methods of transmission of microorganisms?
8. How do you describe a sterile field?
9. How many inches from the edge of a sterile field should equipment and material be placed?
10. What should you do if there is suspicion that a sterile field has been contaminated?
11. Where are the hands held during a sterile procedure?
12. What is the correct way to hold transfer forceps?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Invite a microbiologist as a guest speaker.
2. Observe prepared slides of some major microorganisms under a microscope.
3. Demonstrate opening a sterile package, adding sterile material to a sterile field, and donning sterile gloves.
4. Have students practice opening a sterile package, adding sterile material to a sterile field, and donning sterile gloves.

ANSWERS TO EVALUATION ITEMS:

1. c
2. d
3. g
4. a
5. b
6. e
7. d
8. f
9. a
10. e
11. b
12. c
13. d
14. b
15. d
16. f
17. b
18. e
19. a
20. c
21. d
22. b
23. d
24. a
25. Contaminated
26. Waist
27. Downward

LESSON PLAN: 12

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I

___ 1. Virulence

___ 2. pH

___ 3. Virus

___ 4. Host

___ 5. Bacteriology

___ 6. Anaerobic organism

Column II

a. Person, animal, or plant which supports a parasite

b. Study of bacteria

c. The disease-producing power of an organism

d. The degree to which a solution is acidic or basic

e. A microorganism that can exit only in the absence of air

f. A microorganism that requires oxygen in order to live

g. Smallest of all microorganisms

Match the term in Column I with the correct definition in Column II.

Column I

____ 7. Inclusion bodies

____ 8. Metazoa

____ 9. Protozoa

____ 10. Pathogenic organism

____ 11. Parasitic organism

____ 12. Aerobic organism

Column II

a. One-celled animals

b. One which uses living organism material as a source of food

c. A microorganism that requires oxygen in order to live

d. Colonies of viruses growing in tissues

e. One which produces disease

f. Multicellular animal forms (e.g. roundworms, tapeworms)

13. An example of a microorganism in the practical classification is: (Circle the letter of the best answer.)

    a. Animal
    b. Protista
    c. Plant
    d. Parasitic

14. An example of a microorganism in the scientific classification is: (Circle the letter of the best answer.)

    a. Pathogenic
    b. Plant
    c. Parasitic
    d. Anaerobic

Match the microorganisms in Column I with the major group of microorganisms in Column II.

Column I

____ 15. One-celled animals

____ 16. Smallest of all microorganisms

____ 17. Yeasts

____ 18. Protista

____ 19. Cocci

____ 20. Multicellular animal forms

Column II

a. Bacteria

b. Fungi

c. Metazoa

d. Protozoa

e. Rickettsial

f. Virus

21. Types of bacteria include: (Circle the letter of the best answer.)

  a. Molds and yeast.
  b. Protozoa and metazoa.
  c. Viruses and rickettsiae.
  d. Staphylococcus and streptococcus.

22. Microorganisms are spread by all of the following except: (Circle the letter of the best answer.)

  a. Moisture in the air.
  b. Sterile items.
  c. Contaminated food.
  d. Contact of secretions.

23. A sterile field is an area which is: (Circle the letter of the best answer.)

  a. Clean and neat.
  b. Dirty from use.
  c. Moist and wet.
  d. Free of germs.

24. When a sterile field is correctly set up, all equipment should be: (Circle the letter of the best answer.)

  a. Two inches from the edge of the sterile field.
  b. One inch from the edge of the sterile field.
  c. One-half inch from the edge of the sterile field.
  d. In the center of the sterile field.

25. You should discard the entire sterile field if there is a suspicion that it has been ____________________.

26. During a sterile procedure hands are held above the ____________________________.

27. The tips of transfer forceps must always point _________________________________.

LESSON PLAN: 12

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS: NAME OF STUDENT: ______________

OPEN STERILE PACKAGE

EQUIPMENT:

1. Sterile package

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Check tape seal color or expiration date.		
3. Place package on table with folds up.		
4. Remove tape.		
5. Unfold flap farthest away from you by grasping it with thumb and forefinger.		
6. Open right flap with your right hand by grasping the outer surface with your thumb and forefinger.		
7. Open left flap with your left hand by grasping outer surface with thumb and forefinger.		
8. Touching only the outside of the flap, open flap nearest you.		

The student has satisfactorily completed the procedure "OPEN STERILE PACKAGE" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS: NAME OF STUDENT: ______________

ADD STERILE MATERIAL TO A STERILE FIELD

EQUIPMENT:

1. Sterile package
2. Sterile field

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Check tape seal color or expiration date.		
3. With both hands, grasp each side of the package and pull it apart.		
4. Open package.		
5. Hold over sterile field.		
6. Drop contents onto sterile field.		

The student has satisfactorily completed the procedure "ADD STERILE MATERIAL TO A STERILE FIELD" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

NAME OF STUDENT: ______________

DON STERILE GLOVES

EQUIPMENT:

1. Sterile gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands.		
2. Check tape seal color or expiration date.		
3. Open seal.		
4. Open outer cover by holding edges between the fingers and pulling in opposite directions.		
5. Lift inner covering to expose the gloves.		
6. If gloves are not already powdered, powder hands.		
7. Discard powder packet in waste container.		
8. Pick up right glove with your left hand.		
9. Slip thumb of left hand inside edge of right glove at the wrist.		
10. Grasp glove at edge.		
11. Lift glove free of covering and table.		
12. Step back a few steps.		
13. Curve right hand with thumb toward your palm.		
14. Using a rotating motion, pull glove on with left hand.		
15. When the right glove is on, let go with your left hand. CAUTION: Do not pull cuff over wrist.		
16. Put on left glove by holding gloved fingers of right glove together.		
17. Slip gloved fingers under the cuff of the left glove.		
18. Lift glove clear of table and wrapping.		
19. Curve fingers of left hand with thumb slightly touching the inner aspect of your forefinger.		

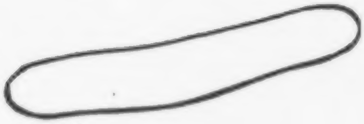
20. Insert left hand into glove by spreading fingers to go into the correct finger opening.		
21. Adjust cuffs by slipping gloved fingers of right hand into cuff of left glove.		
22. Position cuff by pushing toward arm		

The student has satisfactorily completed the procedure "DON STERILE GLOVES according to the steps outlined.

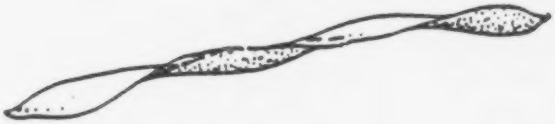
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

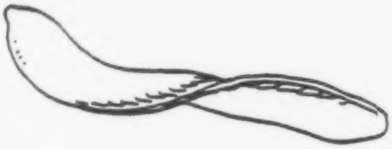
TYPES OF BACTERIA



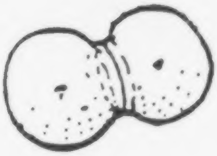
Bacillus



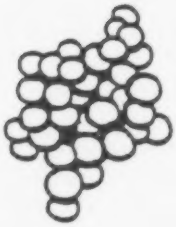
Spirochete



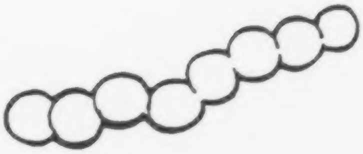
Spirillum



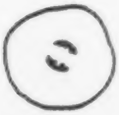
Diplococcus



Staphylococcus



Streptococcus



Coccus

INFECTIOUS COMMUNICABLE DISEASES

	Name	Incubation	Transmitted
1.	AIDS	6 months to 16 years. Average is 4 years.	Virus - direct contact with body secretions of an infected person and blood
2.	Chicken pox	14-21 days	Virus - respiratory; droplet - coughing, sneezing
3.	Type A Hepatitis	2-6 weeks	Virus - feces, oral secretions, intravenous injections, blood
4.	Type B Hepatitis	6 weeks to 6 months	Virus - feces, oral, parenteral injections, blood
5.	Impetigo	1-5 days	Bacteria - direct contact (staph or strep)
6.	Influenza	1-3 days	Virus - droplets, coughing, sneezing, talking, touching a contaminated article
7.	Measles (Rubeola)	9-14 days	Virus - droplet and direct contact
8.	Measles, German Rubella	14-21 days	Virus - droplet and direct contact
9.	Mononucleosis	4-7 weeks	Virus - nose and throat secretions
10.	Mumps	8-30 days	Virus - droplet
11.	Whooping cough pertussis	7-20 days	Bacillus hemophilus - direct contact, droplet
12.	Poliomyelitis	4-14 days	Nose and throat secretions, feces
13.	Scabies	1-2 days	Mites - direct contact, skin
14.	Tuberculosis	varies	Bacteria - droplet, sputum
15.	Lice	7 days	Louse

LESSON PLAN: 13

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

SCOPE OF UNIT:

This unit covers an introduction to microorganisms, the prevention and control of infection, isolation, AIDS, and hepatitis.

INFORMATION TOPIC: IV-13 AND DEMONSTRATION: IV-13

INFECTION CONTROL
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. Identify three requirements for the growth of microorganisms.
3. List five ways bacteria are spread.
4. List four ways viruses are spread.
5. Identify how organisms enter the body.
6. Identify how organisms leave the body.
7. Identify who is considered a susceptible host.
8. Identify Body Substance Precautions.
9. List three specific control measures that prevent the spread of infection.
10. Identify when handwashing should be done.

Demonstration

11. Wash hands according to steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Geri Germ

2. HO 2: Ways Organisms Are Spread
3. HO 3: Stop Sign Alert
4. HO 4: Infection Control
5. HO 5: Biohazard Label
6. Water
7. Soap
8. Paper towel
9. Wastebasket
10. Hand lotion
11. Infection Control Techniques, video #22, available from the Missouri Vocational Resource Center, 12 min.
12. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Surgikos - Protective Asepsis, video (TF #127), 15 min.
    b. Making It Work, video (TF #164), 30 min.
    c. Safe Handwashing, video (TF #49), 10 min.
13. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 13 (Student Reference page 221) prior to class and be prepared to discuss the information presented and return the demonstration on hand washing.

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Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 2.

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INTRODUCTION:

The health care provider is a key in the prevention of infection. A very large number of germs are present in health care facilities due to many people in the facility. People carry germs wherever they go. Germs may be spread from one client to another. In the long-term care facility germs can also be spread in the dining room or day room. Visitors and the health care provider can be the source of infectious organisms.

The health care assistant must understand how infectious diseases are transmitted and steps to prevent the spread of diseases if they are to protect the client, themselves, and others. Remember, the elderly are particularly vulnerable to infections of the respiratory and urinary tract.

LESSON PLAN: 13

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

OUTLINE:

I. Terms and Definitions **(II-1)**

- A. Asepsis - the absence of germs
- B. Aseptic - free of microorganisms
- C. Contaminated - exposed to germs
- D. Germ - microorganism
- E. Infection - invasion of the body by a disease-producing (pathogenic) organism
- F. Micro - means small
- G. Microorganism - a very small living thing (a germ) which can only be seen with a microscope
- H. Pathogens - microbes that cause disease
- I. Resistance - ability to fight off
- J. Toxin - a poisonous substance
- K. Transmitted - transferred or spread
- L. Portal of entry - pathway by which a microorganism enter the body
- M. Portal of exit - route by which organisms leave the body

II. Microorganisms (Microbes) - Bacteria and viruses are the most common in the spread of disease. **(II-2)**

- A. Grow best
  1. At body temperature
  2. Where light is limited
  3. Where there is moisture
  4. Where there is a simple food supply

B. Found everywhere

1. Everything we use in daily living - food, water, objects we touch
2. An object used by others

III. Bacteria (II-3)

A. Some harmful bacteria

1. Staphylococcus
2. Streptococcus
3. Mycobacterium tuberculosis

B. How bacteria are spread

1. Direct contact
    a. Touching the client
    b. Bathing the client
    c. Secretion from the client
    d. Urine from client
    e. Feces from client
2. Indirect contact
    a. Touching objects
    b. Dishes
    c. Bed linen
    d. Clothing
    e. Instruments
    f. Belongings
3. Droplet spread within three feet
    a. Sneezing
    b. Talking

        - c. Coughing
    - 4. Vehicle contaminated
        - a. Food
        - b. Drugs
        - c. Water
        - d. Blood
    - 5. Airborne transmission
        - a. Dust particles
        - b. Moisture in the air
- C. Symptoms of bacterial infection
    - 1. Local infection
        - a. Soreness
        - b. Tenderness
        - c. Redness
        - d. Pus
    - 2. Staphylococcus infection can affect the entire body

IV. Viruses (II-4)

- A. Harmful viruses
    - 1. The smallest microbe in the world
    - 2. Difficult to treat because there are no drugs to use against all virus infections
- B. How viruses are spread
    - 1. Blood
    - 2. Respiratory secretions
    - 3. Enteric excreta (secretions from the entire digestive tract)

4. Secretions from the reproductive tract

NOTE: A virus can only survive in living cells.

C. Symptoms of viral infection

1. Drainage from wounds, eyes, ears, nose
2. Reddened or inflamed area
3. Increased heat in an area
4. Pain
5. Swelling

D. Viral infections

1. Hepatitis
2. Herpes
3. Acquired immunodeficiency syndrome (AIDS)
4. Influenza
5. Common cold
6. Measles

V. Portal of Entry - Organisms Enter the Body (HOs 1 & 2) (II-5)

A. Break in the skin or mucous membranes (staphylococci)

B. Respiratory tract (common cold)

C. Genitourinary tract (syphilis, AIDS)

D. Gastrointestinal tract (salmonellosis, hepatitis)

E. Circulatory system (meningitis, malaria)

VI. Portal of Exit - Organisms Leave the Body (II-6)

A. Excretions from respiratory tract

B. Excretions from genital tract

1. Semen

    2. Vaginal secretions

C. Drainage of wounds

D. Urine

E. Feces

F. Blood

G. Saliva

H. Emesis

I. Excretions from the digestive tract

VII. The Susceptible Host - a person with low resistance or decreased immunity **(II-7)**

A. The elderly client is a susceptible host.

    1. Due to aging process, immune system is not as effective at fighting off infection.

    2. Some diseases and conditions predispose the elderly to infection.

        a. Diabetes mellitus

        b. Congestive heart failure

        c. Dehydration

        d. Malnutrition

        e. Immobility

        f. Hospitalization

        g. Diminished pain sensitivity symptoms

        h. Decreased mental ability (unable to describe illness)

        i. Tumors

        j. Drugs

    3. Nosocomial infection

        a. An infection that develops when a person is in a health care facility

        b. Studies show 2 to 15 percent are nosocomial infections.

c. Most infections are due to:

(1) Infected decubiti

(2) Conjunctivitis

(3) Cystitis/pyelonephritis

(4) Pneumonia

(5) Diarrhea

(6) Influenza

4. Acute phase of infection may be missed in the elderly because of several underlying diseases

a. Fever may not be present

b. They may be receiving medications such as aspirin or steroids for other diseases. They keep the temperature from rising.

c. Decreased sensitivity to pain

d. May develop confusion

e. Fluid and nutritional balance is not maintained

f. Skin loses fat and becomes thin

g. Gastric acid decreases

h. Decreased urinary flow and the presence of catheters may lead to urinary tract infection

i. There may be a decreased cough reflex and less mucus, due to dehydration or medication

VIII. Body Substance Precautions (BSP) - All moist body substances are treated as potentially infectious. (HOs 3 & 4) **(II-8)**

NOTE: Body Substance Precautions (BSP) provides a consistent approach to managing body substances from ALL clients and is essential in preventing transmission of potentially infectious agents. Although not identical with Universal Precautions as recommended by the Centers for Disease Control, the American Hospital Association, and Occupational Safety and Health Administration, BSP is consistent with Universal Precautions. BSP goes a step further and considers ALL blood and body fluids as potentially contagious, regardless of the client's diagnosis.

A. Hands

   1. Wash before and after contact with client.

   2. Always wash after the use of gloves.

   3. If hands come in contact with blood and/or body fluids containing blood, wash immediately with soap and water and report to charge nurse.

   4. Always wash hands before clocking out.

B. Gloves should be worn when contact is likely with:

   1. Any body opening

   2. Blood

   3. Body fluid

   4. Dressings

   5. Used tissues or wipes

   6. Surfaces contaminated with body fluids

   7. When transporting specimen containers

C. Gowns or plastic aprons are to be worn if clothing is likely to soiled by body substances.

D. Mask and/or protective goggles should be worn if it is likely that eyes and mucus membranes will be splashed with body substances.

E. Needles should never be broken, bent, or recapped by hand. Discard in a sharps container.

F. Blood spills and other potentially infectious materials should be cleaned up according to facility policy.

G. Laboratory specimens and containers should be handled and labeled carefully according to facility policy.

NOTE: All laboratory specimens and containers should be labeled with Biohazard labels. (HO 5)

IX. Infection Control **(II-9)**

A. The Center for Disease Control (CDC) located in Atlanta, Georgia, issues guidelines to protect people and prevent the spread of infection.

B. Control of infection at the source

1. Maintain health; have illnesses and infections treated. Report any break in your skin, especially hands.
2. Notify the supervisor if you are ill or infected.
3. Carry out correct handwashing technique.
4. Follow policies for facility disinfection and sterilization.
5. Do your part in housekeeping.
6. Fold and carry clean linen properly.
7. Dispose of soiled disposable articles properly.
8. Keep immunizations up to date.

C. Control of infection at the transmission level

1. Wash hands before and after caring for each client.
2. Follow facility policy for catheter care.
3. Follow Body Substance Precautions.
4. If several clients have the same symptoms, report to the charge nurse immediately.
5. Wear gloves to wipe up any spills of blood and blood products per facility's policy.

D. Control of infection at the client level

1. Know your client and report any abnormal change in behavior or symptoms.
2. Follow the principle of cleaning and giving care from clean to dirty.
3. Observe clients receiving antibiotics for side infections and report these immediately.
4. Prevent decubitus ulcers by giving good nursing care.
5. Do not share articles of personal care between clients.
6. Work toward maintaining nutrition and activity of the client.

7. Use gloves when doing mouth care, perineal care, skin care, and other procedures involving body fluids.

8. Wear masks, gloves, goggles, and gown when caring for the client that might cough or spray mucus discharge as per facility policy.

E. Specific control measures

1. Linen changing

   a. Keep linen away from uniform.

   b. Avoid shaking or fluffing linen.

   c. Place used linen in a nonporous bag (e.g., plastic bag) at the side of the bed, NEVER on the floor. Place closed bagged linen in designated soiled linen container.

   d. Change linen any time it is soiled.

2. Sanitation

   a. Clean, label, and cover all individual utensils and return to bedside table after each use.

      NOTE: Disposable items should not be reused.

   b. Return soiled dishes to dietary department after each meal. Damp-wipe overbed tables.

   c. Each client should have his/her own hygiene supplies and equipment. The equipment should be cleaned regularly and labeled with the client's name.

   d. Transfer (gait) belts should be kept clean.

   e. When cleaning an item or the body, start with the cleanest area and work toward the dirtiest area.

3. Disinfection

   a. A process of destroying as many harmful organisms as possible

   b. See facility's procedure regarding disinfecting thermometers, utensils, shower chairs, bathtubs, bed frames, mattresses, and denture cups.

4. Sterilization

   a. A process that kills all microorganisms

b. Requires special processing and handling

5. Handwashing

a. Our hands carry germs.

b. Good handwashing technique prevents spread of germs.

c. Wash your hands. **(II-10)**

(1) When you first come on duty and before going home

(2) Before and after each client contact

(3) Before and after glove use

(4) After contact with any waste or contaminated material

(5) Before any contact with food

(6) Before and after going to the bathroom or smoking

d. Wash client's hands before meals and at other appropriate times.

e. Any water faucet is always considered contaminated or dirty. **(II-11)**

f. Turn the faucet off with a dry paper towel.

g. Use soap from a dispenser if possible, rather than using bar soap. Bar soap accumulates pools of soapy water in the soap dish which is a good medium for germ growth.

h. Never use the client's bar soap to wash your hands.

i. When washing your hands, always hold hands lower than elbows so germs do not contaminate your arms. **(II-12)**

X. Demonstrate Procedure for Washing Hands.

XI. Summary and Conclusion

A. Terms and definitions

B. Microorganisms (microbes)

C. Bacteria

D. Viruses

E. Portal of entry

F. Portal of exit

G. The susceptible host

H. Body Substance Precautions

I. Infection control

J. Handwashing

K. Review handwashing procedure

You should have a better understanding of germs and the importance of controlling them in the health care environment. Handwashing is so simple but often neglected. Take time to protect everyone--yourself, your family, coworkers, and the clients. The next lesson is on isolation techniques.

LESSON PLAN: 13

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

STEPS OF PROCEDURE FOR WASHING HANDS:

1. Remove watch and/or loose rings if necessary. Roll up your sleeves. (Wash watch and rings if they have come into contact with contaminated material.)

   NOTE: Place watch and/or rings on clean paper towel.

2. Turn on water with knee, foot, or hand controls; adjust temperature so it is comfortable for you.

   CAUTION: Do not turn controls during procedure.

3. Wet hands thoroughly, including two to three inches above wrists; hold hands with wrists lower than elbows and fingertips pointed downward.

4. Apply a generous amount of soap to hands. If using bar soap, rinse it well before lathering and before returning it to the dish.

5. Scrub hands for at least 15 seconds:

   a. Wash palms and back of hands with at least ten circular motions.

   b. Wash fingers and between fingers with at least ten circular motions.

   c. Wash wrists with at least ten circular motions.

6. Rinse wrists and hands well--keep wrists lower than elbows.

7. Dry hands well with paper towel or fresh clean towel, using one for each hand.

8. Turn off faucet with dry paper towel.

9. Discard paper towel. Be careful not to touch the part that touched the faucet.

10. Apply hand lotion if desired.

LESSON PLAN: 13

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

INTERACTION ITEMS:

1. **Define asepsis, contaminated, infection, microorganism, germ, resistance, aseptic, toxin, and transmitted.**
2. **Where do microorganisms grow best?**
3. **How are bacteria spread?**
4. **How are viruses spread?**
5. **How do organisms enter the body?**
6. **How do organisms leave the body?**
7. **What is the definition of a susceptible host?**
8. **What kind of things do you do every day at work to control the spread of germs?**
9. **When should health care assistants wash their hands?**
10. **Why are the faucet controls not turned during the handwashing procedure?**
11. **Why do we keep our hands lower than our elbows during the handwashing procedure?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Have a group discussion of interaction items.**
2. **Observe handwashing technique where you work. Report to the class difference you see from what is recommended.**
3. **Have a class discussion on what to do if you see someone handling blood without gloves.**
4. **Instructor demonstrates handwashing procedure.**
5. **Students should wash hands according to the steps of procedure.**
6. **Show audiovisuals.**

ANSWERS TO EVALUATION ITEMS:

1. f
2. g
3. d
4. b
5. c
6. a
7. e
8. d

9. direct contact, indirect contact, droplet spread within three feet, vehicle contaminated, and airborne transmission

10. blood, respiratory secretions, enteric excreta from digestive tract, secretions from the reproductive tract

11. d
12 a
13. a
14. d
15. c
16. d
17. b
18. dirtiest
19. d

LESSON PLAN: 13

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

Match the following terms in Column I to correct definitions in Column II.

Column I

___ 1. Asepsis

___ 2. Resistance

___ 3. Transmitted

___ 4. Contaminate

___ 5. Toxin

___ 6. Microorganism

___ 7. Infection

Column II

a. A very small, living thing

b. To soil, stain or pollute

c. A poisonous substance

d. Transferred or spread

e. Condition in body tissue in which germs have multiplied and destroyed many cells

f. Free of disease-causing microorganisms; sterile

g. Ability to fight off

8. In what condition do microorganisms grow best? (Circle the letter of the best answer.)

   a. At a high temperature
   b. Where there is a lot of sunlight
   c. Where there is an absence of moisture
   d. At body temperature

9. List five ways bacteria are spread.

   a.
   b.
   c.
   d.
   e.

10. List four ways viruses are spread.

   a.
   b.
   c.
   d.

11. What is a method of entry for organisms? (Circle the letter of the best answer.)

    a. Breaks in the skin or mucus membrane
    b. Respiratory tract
    c. Gastrointestinal tract
    d. All of the above

12. Organisms leave the body through all of the following except through ____________. (Circle the letter of the best answer.)

    a. Excessive perspiration
    b. Drainage of wound
    c. Saliva and blood
    d. Urine and feces

13. Which of the following is not a reason why the elderly client is considered a susceptible host for diseases? (Circle the letter of the best answer.)

    a. Poor nursing care is administered in all nursing homes.
    b. Infections in the elderly may be missed because of underlying diseases.
    c. Some infections characteristically develop when a person is in a nursing home.
    d. The immune system is not as effective at fighting off infections.

14. Which of the following is considered "Body Substance Precautions"? (Circle the letter of the best answer.)

    a. Always break, bend, and recap needles.
    b. Only wash your hands after giving the client a bedpan.
    c. Do not wash hands after removing gloves.
    d. Gloves should always be worn when there is contact with body fluids.

15. Which of the following specific control measures does not prevent the spread of infection? (Circle the letter of the best answer.)

    a. Keep soiled linens away from uniform.
    b. Only use the client's personal hygiene equipment.
    c. Shake and fluff linens before placing them in bag.
    d. Always wash your hands after contact with each client.

16. The most important measure the health care assistant can do to prevent the spread of disease is: (Circle the letter of the best answer.)

    a. Wear a mask.
    b. Sterilize all equipment.
    c. Wear a gown.
    d. Wash hands.

17. Which one of the following is a means of controlling infection in a health care facility: (Circle the letter of the best answer.)

    a. Carry linens close to your uniform.
    b. Never place linens on the floor.
    c. Shake and fluff linens before making the bed.
    d. Carry dirty linens at arm's length.

18. Always clean an item from the cleanest area to the ______________________________.

19. Proper handwashing procedure for the health care assistant includes: (Circle the letter of the best answer.)

    a. Adjusting water temperature during the procedure.
    b. Scrubbing hands five (5) minutes.
    c. Turning off the faucet with a wet paper towel.
    d. Washing hands two to three inches above the wrist.

LESSON PLAN: 13

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

NAME OF STUDENT: ______________

WASH HANDS

EQUIPMENT:

1. Water
2. Soap
3. Paper towels
4. Wastebasket
5. Hand lotion

CHECK IF THE STUDENT DID THE FOLLOWING		YES	NO
1.	Remove watch and/or rings, roll up sleeves. (Wash watch and rings if they have come into contact with contaminated materials.) NOTE: Place watch and/or rings on clean paper towel.		
2.	Turn on water with knee, foot, or hand controls, adjust temperature so it is comfortable for you. CAUTION: Do not turn controls during procedure.		
3.	Wet hands thoroughly, including and 2"-3" above wrists; hold hands with wrists lower than elbows and fingertips pointed downward.		
4.	Apply generous amount of soap to hands. If using bar soap, rinse it well before lathering and before returning it to the dish.		
5.	Scrub hands for at least 15 seconds: a. Wash palms and back of hands with at least ten circular motions.		
	b. Wash fingers and between fingers with at least ten circular motions.		
	c. Wash wrists with at least ten circular motions.		
6.	Rinse wrists and hands well; keep wrists lower than elbows.		
7.	Dry hands well with paper towel or fresh clean towel, using one for each hand.		
8.	Turn off faucet with dry paper towel.		

9.	Discard paper towel. Be careful not to touch the part that touched the faucet.		
10.	Apply hand lotion if desired.		

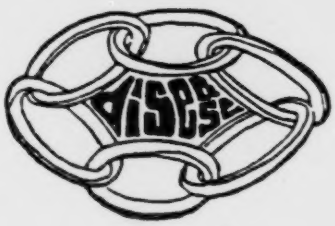
The student has satisfactorily completed the procedure "WASH HANDS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

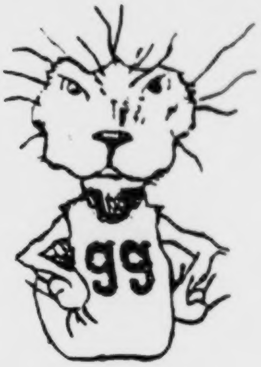
GERI GERM

As a Nurse Assistant, you need to understand **Epidemiology** (the science of the occurrence of disease) for there is more disease in a health facility than in ordinary households. **Health is desirable - Disease is undesirable.** So, in order to control disease we must know why it exists and how it develops. Then we can strike at its most vulnerable spot. **A Chain of Events creates disease.** If any link is broken, disease will not develop. **A simple thing like Handwashing can break the chain!**



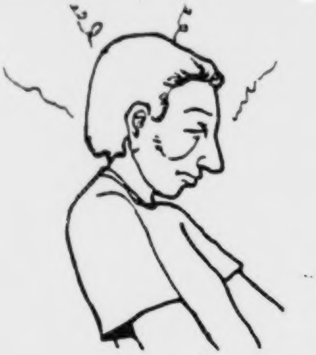
THE SIX LINKS OF THE CHAIN

FIRST LINK - Causative Agent: (bacteria, parasite, virus)



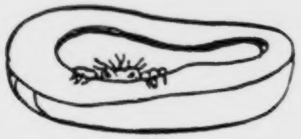
Introducing Geri Germ, the awful organism who causes disease.

SECOND LINK - Reservoir for Causative Agent: (sick person or animal)



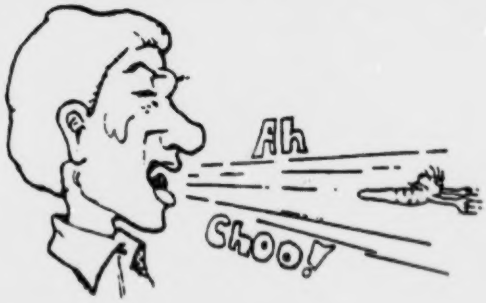
A place where Geri can live.

THIRD LINK - Mode of escape from reservoir: (respiratory tract, intestinal tract, urinary tract, blood stream)

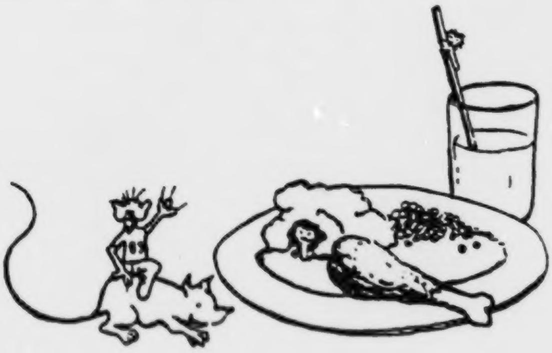


Geri uses all of these as escape routes.

FOURTH LINK - Mode of Transmission from reservoir to new host (person):



Direct: Sneeze, cough, bite, shots, open lesions, physical contact.

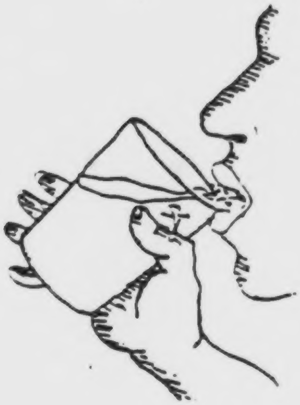


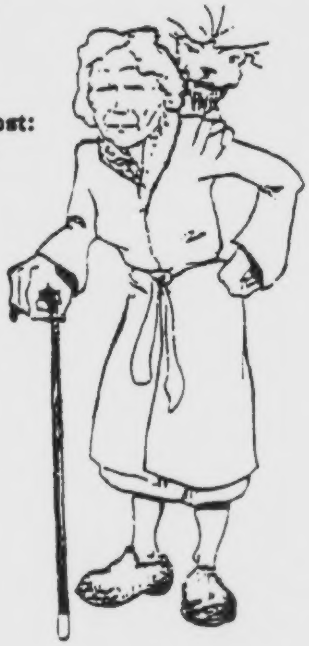
Indirect: Vector (rats, mice, roaches, flies) food, air, or water on articles.

BEST COPY AVAILA

FIFTH LINK - **Mode of entry into new host (person): (breathing, eating, breaks in skin.)**
Study Nursing Procedures.

SIXTH LINK - **A susceptible host: (low resistance, no immunity)**





'**Infection**' means an organism is present and multiplying in the body.

'**Disease**' is the visible interaction between the organism and the infected body.

'**Symptoms**' are fever, rash, malaise, nausea, and diarrhea.

The Severity of Diseases depends on the strength of the opposing forces.

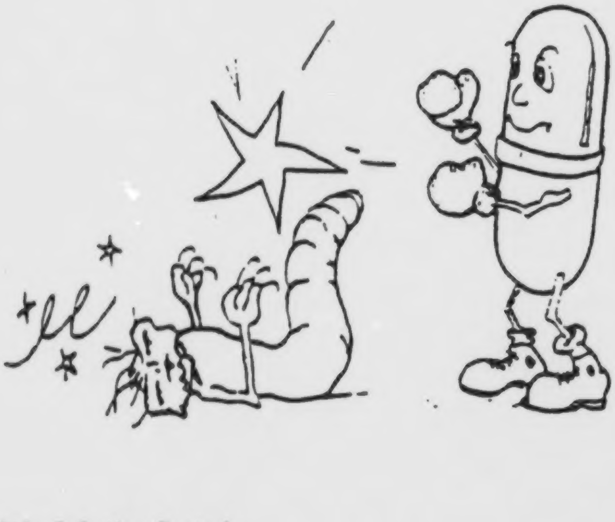
Levels of Severity

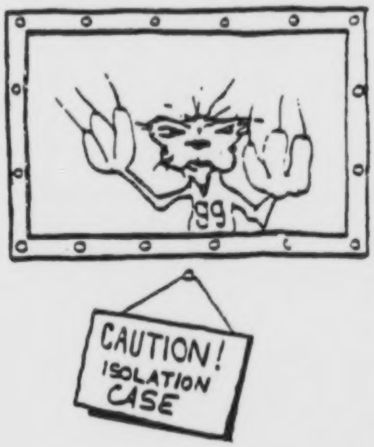
Death
Severe
Moderate
Mild
Missed Case
Carrier
No Infection

Expose more people because they are not very sick

Control Measures

Prevent Spread: (Medication to kill organisms.)
By physician's order.





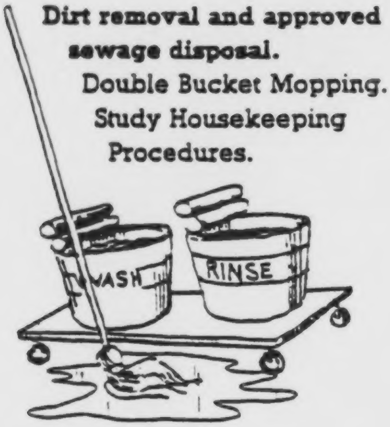
Isolate the sick person:
Study special nursing procedures.
Handwashing must be done.

Control Measure **Environmental Sanitation**

Dirt removal and approved sewage disposal.

Double Bucket Mopping.

Study Housekeeping Procedures.



Clean Air

U.S.D.A.
GRADE A
INSPECTED

Approved Food Source

WATER
APPROVED BY
MISSOURI DEPT.
OF
QUAL

Pure Water Source

DISINFECTANT
CHEMICAL SOLUTION
STERILIZATION
STEAM UNDER PRESSURE

Insect and Rodent Control

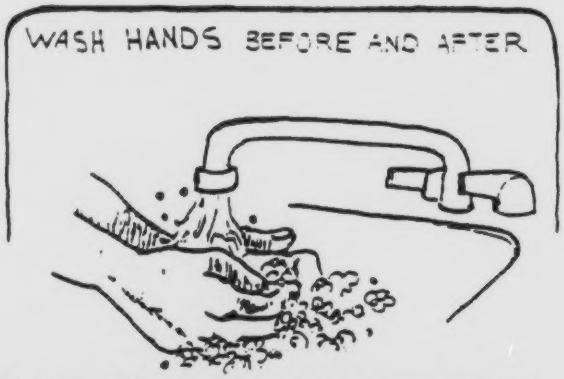
Disinfection
(chemical solution)

Sterilization
(steam under pressure)

Study Nursing Procedures

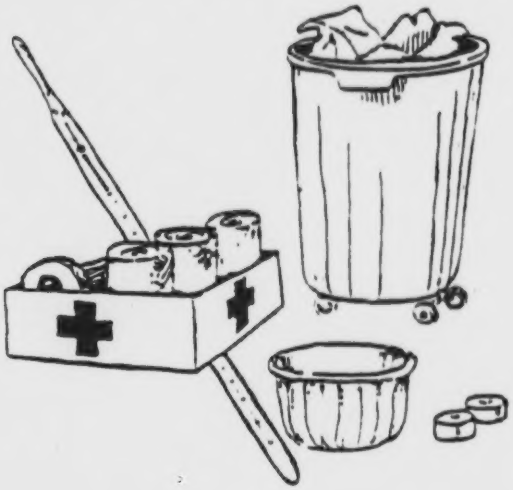
BUG
SPRAY
RAT
POISON

Geri Germ likes: warm places, moist places, dark places, and dirty, cluttered places.


WASH HANDS BEFORE AND AFTER

Handwashing is the most important factor!
Study other Procedures, all departments.

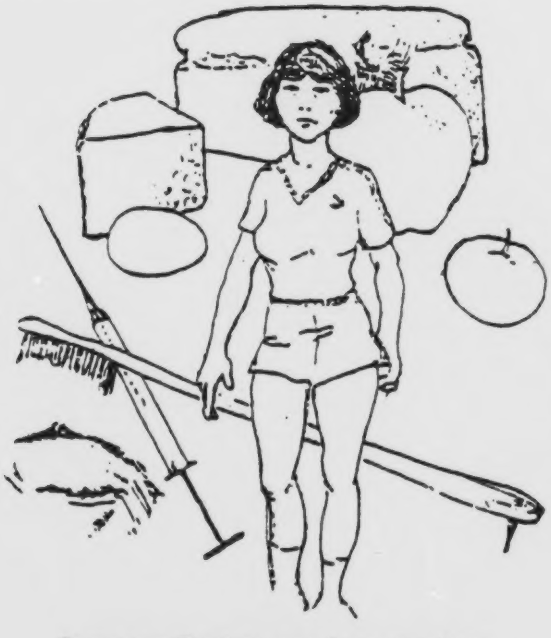
Environmental Sanitation



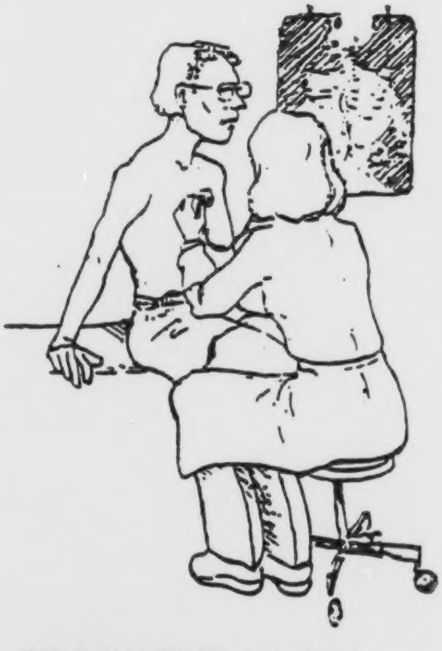
Nursing Procedures

Closed System Irrigation
Proper Linen Handling
Sterile Dressings
Sanitary Medications
Proper Disinfection of Thermometers

CONTROL MEASURES



Increase Resistance: keep healthy, immunizations, sleep, eat properly, exercise, good hygiene.

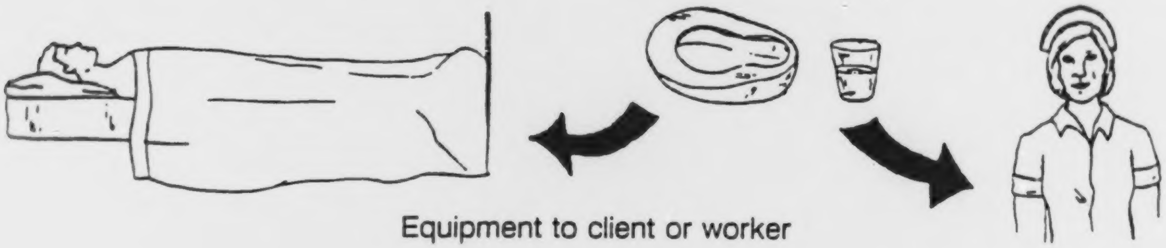


Minimize ill effects: early diagnosis (regular medical examinations), Early treatment

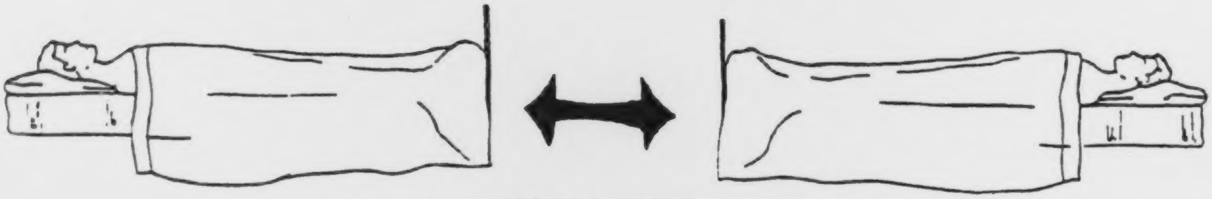
*(Concept by Ann Wormsley)

HO 2

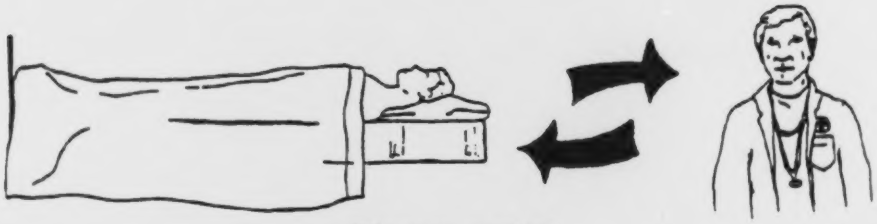
WAYS ORGANISMS ARE SPREAD



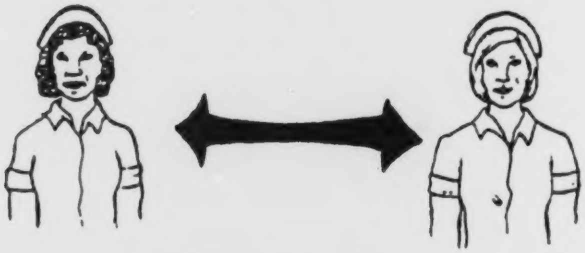
Equipment to client or worker



Client to client



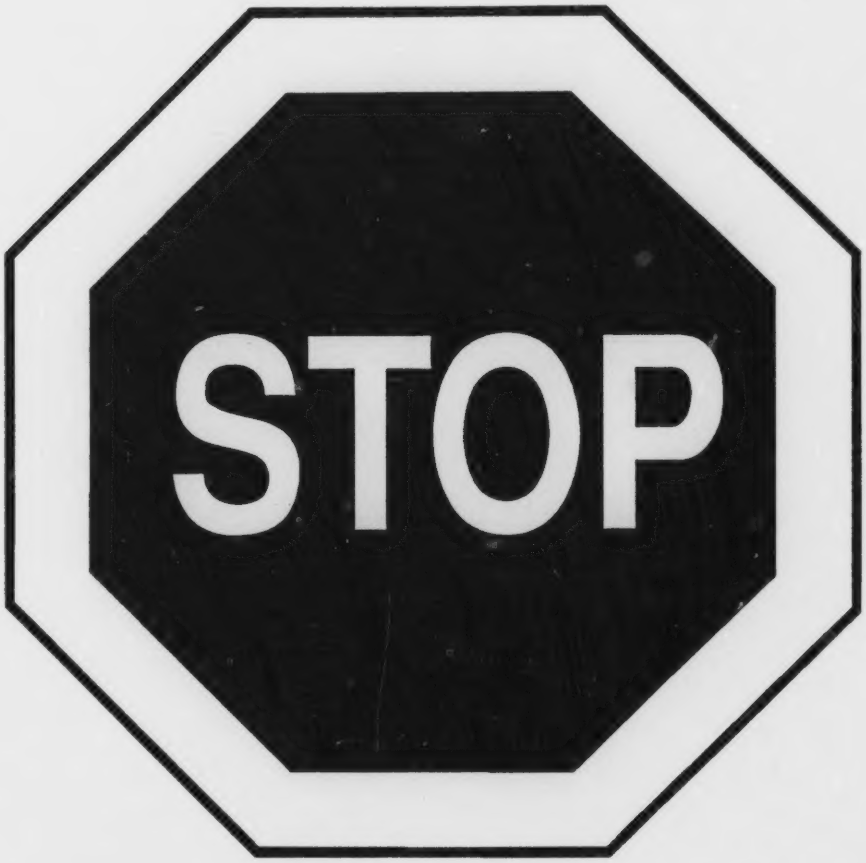
Client to worker
Worker to client



Worker to worker

HO 3

STOP SIGN ALERT



SEE THE NURSE BEFORE ENTERING

INFECTION CONTROL

A system of infection prevention and control currently in use is called Body Substance Precautions (BSP). This system focuses on keeping all moist body substances (blood, feces, urine, wound drainage, tissues, oral secretions, and other body fluids) from the hands of personnel. This is done primarily by increased glove usage and handwashing. The Body Substance Precautions system is consistent with recommendations from the Centers for Disease Control (CDC), the American Hospital Association, and Occupational Safety and Health Administration (OSHA) that point out the need to consider ALL blood and ALL body fluids as potentially contagious regardless of the client's diagnosis. In order to comply with the CDC policies, the following recommendations should be used. The need to use barriers must focus on the caregivers' (health care assistants') routine contact with the clients.

Because a medical history and examination cannot reliably identify all persons with infectious diseases, we treat ALL blood and body substances as potentially infectious rather than to focus precautions only on the clients that are diagnosed with infectious diseases.

Implementing the Body Substance Precautions System includes the following elements and should be followed by ALL personnel at all times, regardless of the client's diagnosis.

Body Substance Precautions

1. Wear gloves when it is likely that hands will be in contact with mucous membranes, non-intact skin and/or any moist body substance, (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, or items/surfaces soiled with these substances). Gloves should be changed and hands washed between clients. If a glove is torn or a needle stick or other injury occurs, the glove should be removed, discarded in appropriate container, hands washed, and a new glove used promptly as client safety permits.

   REMEMBER: Gloves are not a cure-all. They reduce the likelihood of contaminating the hands, but hands should be washed after removal of the gloves.

   a. Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other client care procedures.

   b. Change gloves and wash hands between clients.

   c. Do not wash or disinfect examination gloves for reuse.

   d. Use general purpose utility gloves (e.g., rubber household gloves) for housekeeping or instrument cleaning involving blood contact. These utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored; or if they have punctures, tears, or other evidence of deterioration.

2. Wash hands often, always between clients' care and after any contact with body substances or contaminated materials. Pay particular attention to around and under fingernails and between fingers. Always keep your hands away from your face or you may give (inoculate) yourself with the infectious organisms.

3. Wear masks and/or eye protection when it is likely that eyes or mucous membranes will be splashed with body substances (your charge nurse will give you further direction).

4. Protect your clothing with a plastic apron or gown when it is likely that clothing will be soiled with body substances.

5. Health care workers with draining lesions or weeping dermatitis must refrain from all direct client care and from handling client care equipment until cleared by a physician. These conditions put the employee and the client at risk of infection.

6. Discard trash in plastic bags according to facility policy.

7. If the client has a disease which is transmitted in whole or part by the airborne route, use the "Stop Sign Alert" on the client's door. This will allow the nurse to give the individuals wishing to enter the room specific instructions regarding the client (e.g., tuberculosis). The nurse instructs non-immune persons to not enter the room of persons with specific diseases (e.g., chicken pox, measles, mumps). Precautions for clients with airborne diseases include: private room, "Stop Sign Alert" on door, and door closed.

8. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

Some Examples of Situations Using the Body Substance Precautions System

1. Follow Body Substance Precautions when caring for clients with bowel and/or bladder problems.

   It is difficult to clean an incontinent client without getting urine and/or stool on the hands. Gloves should be worn routinely and for helping clients with toileting activities. One major risk is getting germs underneath the caregiver's fingernails. Gloves reduce this risk and make handwashing after completing the task easier and more efficient. A plastic gown may also be needed for cleaning incontinent clients and for changing their clothes and the bed linen. Obtain the plastic apron before the tasks are begun.

2. When a care provider is emptying a urinary catheter bag, this should be viewed as a single interaction to a single client and the tasks for one client should be completed before going to the next client.

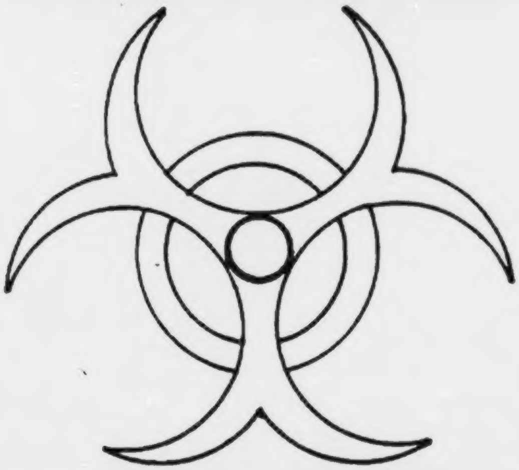
   Wearing gloves for emptying catheter bags is wise because it is difficult not to get urine on your hands. It is unacceptable to consider it a single task to empty the catheter bags for several clients in sequence without changing gloves and washing hands between clients. This is because of the real risk of transmitting organisms from the catheter bag drainage spout of one client to the next client's drainage spout on the hands of personnel.

3. When a client has a rash or skin lesions on his/her body, it could be due to any number of causes. The lesions may be due to varicella (chicken pox or zoster), herpes simplex, scabies, syphilis, impetigo, a drug reaction or other causes. Prompt recognition of the rash, identification of the cause, prompt appropriate intervention, and proper usage of gloves and handwashing can prevent transmission of organisms to other clients and care providers.

HO 5

BIOHAZARD LABEL

BIOHAZARD



LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

SCOPE OF UNIT:

This unit covers an introduction to microorganisms, the prevention and control of infection, isolation, AIDS, and hepatitis.

INFORMATION TOPIC: IV-14 AND DEMONSTRATION: IV-14

ISOLATION TECHNIQUES
(Lesson Title)

OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

Information

1. Match terms in this lesson with their correct definitions.
2. Describe the purpose of isolation techniques.
3. Identify feelings the client in isolation may experience.
4. Match each type of isolation to the correct reason for its use.
5. Identify proper isolation techniques.
6. Identify important factors when following isolation procedure.
7. State the definition of terminal disinfection.

Demonstration

8. Don and remove daily care nonsterile gloves.
9. Don and remove mask.
10. Don and remove gown.
11. Transfer of contaminated articles in the isolation room to the outside. (double bagging)
12. Collect specimen in an isolation room.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Double Bagging
2. Isolation gown
3. Mask
4. Gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 14 (Student Reference page 249) prior to class and be prepared to discuss the information presented and return the demonstrations.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 14.

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INTRODUCTION:

Isolation is indicated when a client has an infection that could be easily spread. The type of isolation is dependent upon what type of infection the client has and how it might be spread. It is important for the health care assistant to have a basic understanding of the isolation techniques as presented in this lesson.

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

OUTLINE:

I. Terms and Definitions **(II-1)**

   A. Clean - an area or object which is not contaminated by microorganisms

   B. Dirty - an area or object which is contaminated by harmful microorganisms

   C. Isolation technique - special procedures to prevent the spread of harmful microorganisms

   D. Nosocomial - an infection acquired while in a health care facility

   E. Contaminated - unclean; soiled

   F. Sterile - absence of microorganisms

   G. Sterilization - special procedure to destroy all microorganisms

II. Isolation Techniques **(II-2)**

   A. Isolation technique is a method of caring for clients with easily transmitted diseases.

   B. Purposes

      1. This technique is used to prevent the spread of disease-producing germs (pathogens).

      2. It protects the infected client from further infection.

      3. It protects uninfected clients, visitors, and staff from being infected.

      4. Body Substance Precautions do not eliminate the need for isolation precautions.

   C. Type of isolation depends upon the type of infection. A "Stop Sign Alert" card is placed on the door of the isolation unit to identify the need to check with the charge nurse before entering.

III. Client's Feelings About Isolation **(II-3)**

   A. Client may feel lonely, rejected, or "dirty."

B. Assist the client in dealing with being in isolation.

  1. Explain to the client the reason for isolation. Point out that this will speed up his/her recovery and prevent the spread of the germs that caused the disease.

  2. Check the client at regular intervals so he/she does not feel isolated from the rest of the world. Make sure other staff members know how important it is to check on the client.

  3. Listen to the client's concerns.

  4. Provide assurance to the client.

  5. Make certain the client has contact with staff and visitors. The need for communication, stimulation, and touch still exists.

IV. Types of Isolation **(II-4)**

A. Strict isolation

  1. Used to prevent the spread of highly communicable diseases by contact or through the air

  2. Protects others from the client's germs

  3. Examples: burn wounds, infections caused by staphylococcus and streptococcus

B. Respiratory isolation

  1. Used to prevent spread of disease by droplets that are coughed, sneezed, or breathed into the air

  2. Protects others from the client's germs from respiratory system

  3. Examples: chicken pox, mumps, tuberculosis

C. Wound and skin precautions

  1. Used with infections that are spread by coming in direct contact with wound, linen, or dressing

  2. Protects others from germs in client's wounds and heavily contaminated articles

  3. Examples: impetigo, infected decubitus ulcers

D. Enteric precautions

1. Used with diseases that are spread through urine, feces, and heavily contaminated articles; spread of the infection involves taking in the germ through the mouth

2. Protects others from germs in client's bowels, bladder, and stomach

3. Examples: hepatitis, infections caused by diarrhea

E. Protective isolation (reverse)

1. Used with persons who have a seriously decreased ability to resist disease

2. Protects client from the germs of other people

3. Examples: leukemia, burns, client on chemotherapy

F. Blood/body fluid precautions

1. Used with diseases spread by blood and body fluids

2. Examples - AIDS, hepatitis

V. Key Points in Isolation Techniques **(II-5)**

A. Mask

1. Make certain your hands are clean before putting on mask or taking mask off.

2. Masks are effective for only 30 minutes due to moisture of normal respiration.

3. Use only once and throw away.

4. If mask becomes wet, change it.

5. Never let a mask hang around your neck.

6. Mask must fit snugly over mouth and nose.

B. Gown

1. Use only once and discard.

2. Gown must completely cover your uniform.

3. If you are wearing a uniform with long sleeves, roll sleeves above your elbows before gowning.

C. Serving food

   1. You may not be required to wear a gown when serving food. Make certain your uniform does not become contaminated.

   2. Wear gown if there is a need to assist client with eating.

   3. Uneaten food is considered contaminated.

   4. Dispose of disposable dishes and tray in trash container in client's room.

D. Double bagging (HO 1)

   1. Double bagging requires two people, one inside the room and one outside the room.

   2. Contaminated items are placed in appropriate container inside the room and container is sealed.

   3. Sealed bag is placed inside another bag outside the room which is held by second person.

VI. Important Factors **(II-6)**

A. Be aware of and follow the measures being taken for each type of isolation.

   1. There should be a "Stop Sign Alert" card posted for isolation. Follow recommendations given to protect everyone.

   2. Gowns, gloves, and/or masks may be required for the health care assistant. For full isolation, the health care assistant should put on the protective clothing in the following order: cap, mask, gown, and gloves.

B. Always organize your work before going into the room.

   1. Gather all supplies and linens needed.

   2. Inform other staff members if you will be needing their assistance.

C. Remember to wash hands before and after contact with the client. This remains the single most important means of preventing the spread of infection.

D. Gloves do not eliminate the need to wash your hands, they just provide a barrier between you and the client.

E. Articles or linens removed from an isolation room must be completely covered with a noncontaminated container.

F. The thermometer and blood pressure apparatus may be left in the room and not taken out of the room until the isolation is discontinued.

G. Never touch unnecessary articles in the room or one's face, hair, contact lens, or glasses when wearing gloves.

VII. Terminal Disinfection **(II-7)**

Terminal disinfection is a thorough cleaning of the room with disinfectant solution after isolation is discontinued.

VIII. Demonstrate Procedures for Isolation Techniques.

IX. Summary and Conclusion

A. Terms and definitions

B. Isolation techniques

C. Client's feelings about isolation

D. Types of isolation

E. Key points in isolation techniques

F. Important factors

G. Terminal disinfection

H. Review procedures for isolation techniques.

The next lesson is on AIDS and the health care assistant.

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

STEPS OF PROCEDURE FOR DONNING AND REMOVING DAILY CARE NONSTERILE GLOVES:

Donning gloves:

1. Wash and dry hands.

2. Remove gloves from box, one at a time.

3. Place your hand through opening and pull the glove up to the wrist.

4. Repeat with second glove.

5. Adjust gloves to cover your wrists or cuffs of gown.

6. Complete client care.

Removing gloves:

7. Grasp one glove on the inside of wrist at 1/2" below band of dirty side of glove without touching your skin.

8. Pull glove down turning it inside out to cover the thumb and finger line.

   CAUTION: Do not completely remove the glove.

9. With covered thumb and finger, pinch second glove at inside wrist area.

10. Pull glove down until it is inside out over fingers.

11. Touch only inside surfaces of gloves and remove gloves from both hands.

12. Discard gloves by dropping them in appropriate container.

13. Wash hands.

STEPS OF PROCEDURE FOR DONNING AND REMOVING MASK:

Donning mask:

1. Wash hands.

2. Pick up mask.

3. Adjust mask over your nose and mouth.

4. Tie top string behind head.

5. Tie lower string behind head.

6. Complete client care.

   NOTE: Replace mask if it becomes moist.

Removing mask:

7. Wash hands.

   NOTE: If wearing gloves remove them before washing hands.

8. Untie bottom string.

9. Untie top string.

10. Remove by holding top strings.

11. Discard by dropping mask in approved container in client's room.

12. Wash hands.

STEPS OF PROCEDURE FOR DONNING AND REMOVING GOWN:

Donning gown:

1. Remove wrist watch and place on clean side of a paper towel.

2. Wash hands.

3. Don mask if necessary for procedure.

4. Unfold gown with opening at the back.

5. Put on gown by slipping arms into sleeves.

6. Slip fingers inside neck band.

7. Tie neck tie in back or fasten strips.

8. Grasp waist ties in front and bring to back.

9. Reach behind and overlap edges of gown.

10. Bring waist ties in front and tie.

11. Don gloves.

12. Complete client care.

Removing gown:

13. Untie waist tie.

14. Remove gloves and dispose in appropriate container in the room.

15. Turn faucet on with clean paper towel.

16. Wash and dry hands.

17. Turn off faucet with clean, dry paper towel.

18. If wearing mask, remove mask holding it by ties only and discard in approved container.

19. Untie ties at neck and loosen gown at neck.

20. Slip fingers of one hand inside the cuff of the other hand.

    NOTE: Do not touch the outside of the gown.

21. Pull gown down over hand.

22. With gown-covered hand, pull gown down over other hand.

23. Fold gown away from your body with contaminated side inward.

24. Roll gown into a ball.

25. Discard gown in proper receptacle.

26. Turn on faucet with clean paper towel.

27. Wash hands.

28. Turn off faucet with clean, dry paper towel.

29. Remove watch from clean side of paper towel.

30. If in isolation, open door with paper towel. Use toe to keep door open while disposing towel in trash receptacle before leaving client's room.

31. Wash hands.

STEPS OF PROCEDURE FOR DOUBLE BAGGING:

NOTE: Health care assistant in isolation room is gloved and if appropriate, gowned and masked.

1. Call for assistance while in the isolation room.

2. The person assisting will remain outside the isolation room.

3. Place article into a plastic bag while inside the isolation room.

4. Tie bag while in the isolation room.

5. The person assisting should hold cuffed plastic bag outside the unit. Hands are protected by being under the cuff.

6. Person inside isolation unit comes to the door and places contaminated bag into clean bag.

7. Person assisting outside the room ties clean bag without touching the inside of the bag.

8. Clean person discards bag in appropriate area.

STEPS OF PROCEDURE FOR COLLECTING A SPECIMEN IN AN ISOLATION ROOM

NOTE: Health care assistant in isolation room is gloved and if appropriate gowned and masked.

1. Lay a clean paper towel on the bedside stand.

2. Place a clean specimen container on the paper towel.

3. Place specimen in container without touching the container.

4. Dispose of the receptacle in which the specimen was collected according to facility policy.

5. Remove disposable gloves.

6. Wash and dry hands.

7. Put on a new pair of disposable gloves.

8. Cover specimen and label container.

9. Double bag specimen. Follow double bagging procedure.

NOTE: The person assisting outside the isolation room takes the specimen to the laboratory.

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

INTERACTION ITEMS:

1. What is the definition of clean, dirty, isolation technique, nosocomial infection, contaminated, sterile, sterilization, universal precautions?
2. What is the purpose of isolation techniques?
3. How would you describe the feelings of a client left alone in isolation for three or four days with few visitors?
4. What are the five types of isolation and the use of each?
5. What key points of isolation techniques should the health care assistant know in relation to the mask, gown, serving food, and double bagging?
6. What important factors should the health care assistant follow when caring for the client in isolation?
7. What is terminal disinfection?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates how to gown, mask, and glove before entering and leaving strict isolation room.
2. Students practice donning and removing gown, mask, and gloves. Practice handwashing as well.
3. Instructor demonstrates serving food and double bagging.

ANSWERS TO EVALUATION ITEMS:

1. c
2. f
3. a
4. d
5. e
6. b
7. c
8. e
9. c

10. b
11. a
12. d
13. d
14. a
15. c
16. Two
17. c
18. A thorough cleaning of the room with disinfectant solution after isolation is discontinued

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

Match the terms in Column I with their correct definitions in Column II.

Column I		Column II	
___ 1.	Nosocomial	a.	An area or object which is not contaminated by microorganisms
___ 2.	Sterile	b.	Special procedures and practices to follow when caring for clients
___ 3.	Clean	c.	An infection acquired while in a health care facility
___ 4.	Dirty	d.	An area or object which is contaminated by harmful microorganisms
___ 5.	Isolation technique	e.	Special procedures to prevent the spread of harmful microorganisms
		f.	Absence of microorganisms

6. Which one of the following correctly explains the purpose of isolation technique? (Circle the letter of the best answer.)

   a. It provides a private room for the client.
   b. It prevents the spread of germs to uninfected clients, visitors, and staff.
   c. It does not protect the infected client from further infection.
   d. It only protects the client not the health care assistant.

7. Which one of the following best describes how a client may feel when left alone in isolation for a few days with no visitors? (Circle the letter of the best answer.)

   a. Client will feel safer not having visitors to bother him/her.
   b. Client will be very angry with the nurse for having put him/her in isolation.
   c. Client may feel dirty, lonely, or rejected.
   d. Client really doesn't care if there are no visitors.

Match each type of isolation in Column I to the correct reason for its use in Column II.

Column I

___ 8. Protective

___ 9. Wound and skin

___ 10. Respiratory

___ 11. Strict

___ 12. Enteric

Column II

a. Used to prevent spread of communicable diseases by direct contact or through the air

b. Used to prevent spread of disease by airborne droplets

c. Used with infections that are spread by direct contact with wounds

d. Used with diseases spread by body excretions

e. Used with persons who have seriously decreased ability to resist disease

13. When wearing a mask you should: (Circle the letter of the best answer.)

    a. Wear the same mask all day.
    b. Let the mask hang around your neck when you are in the hallway.
    c. Cover only your mouth with the mask so you can breath.
    d. Use the mask only once and throw it away.

14. Which one of the following is true concerning the isolation gown? (Circle the letter of the best answer.)

    a. The gown must completely cover your uniform.
    b. The gown can be reused if it is not dirty.
    c. It is not necessary to cover the sleeves of your uniform.
    d. To conserve supplies, you should always reuse the gown.

15. When serving food to a client in isolation, you should: (Circle the letter of the best answer.)

    a. Use china plates and silverware.
    b. Wash the dishes before removing them from the room.
    c. Dispose of disposable dishes and trays in trash container in the isolation room.
    d. Always wear a gown when serving food to the client in isolation.

16. Double bagging requires __________________ people.

17. Which of the following is not an important factor to remember when caring for a client in isolation? (Circle the letter of the best answer.)

   a. Wash your hands before and after contact with the client.
   b. Gather all supplies needed before going into the isolation room.
   c. Gloves will eliminate the need to wash your hands.
   d. Never touch your face, hair, contact lens, or glasses when wearing gloves.

18. Define terminal disinfection.

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS: NAME OF STUDENT: ____________

DON AND REMOVE DAILY CARE NONSTERILE GLOVES

EQUIPMENT:

1. Water
2. Soap
3. Paper towels
4. Nonsterile gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
Donning gloves: 1. Wash and dry hands.		
2. Remove gloves from box, one at a time.		
3. Place your hand through opening and pull the glove up to the wrist.		
4. Repeat with the second glove.		
5. Adjust gloves to cover your wrists or cuffs of gown.		
6. Complete client care.		
Removing gloves: 7. Grasp one glove on the inside of wrist at 1/2" below band of dirty side of glove without touching your skin.		
8. Pull glove down turning it inside out to cover the thumb and finger line. CAUTION: Do not completely remove the glove.		
9. With covered thumb and finger, pinch second glove at inside wrist area.		
10. Pull glove down until it is inside out over fingers.		
11. Touch only inside surfaces of gloves and remove gloves from both hands.		
12. Discard gloves by dropping them in appropriate container.		
13. Wash hands.		

The student has satisfactorily completed the procedure "DON AND REMOVE DAILY CARE NONSTERILE GLOVES" according to steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) ____________

Date ____________

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS: NAME OF STUDENT: ______________

DON AND REMOVE MASK

EQUIPMENT:

1. Water
2. Soap
3. Mask

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
Donning mask: 1. Wash hands.		
2. Pick up mask.		
3. Adjust mask over your nose and mouth.		
4. Tie top string behind head.		
5. Tie lower string behind head.		
6. Complete client care. NOTE: Replace mask if it becomes moist.		
Removing mask: 7. Wash hands. NOTE: If wearing gloves, remove them before washing hands.		
8. Untie bottom string.		
9. Untie top string.		
10. Remove by holding top strings.		
11. Discard by dropping mask in approved container in client's room.		
12 Wash hands.		

The student has satisfactorily completed the procedure "DON AND REMOVE MASK" according to steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

NAME OF STUDENT: ______________

DON AND REMOVE GOWN

EQUIPMENT:

1. Water
2. Soap
3. Paper towels
4. Gown
5. Mask (optional)
6. Gloves (optional)

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
Donning gown: 1. Remove wrist watch and place on clean side of a paper towel.		
2. Wash hands.		
3. Don mask if necessary for procedure.		
4. Unfold gown with opening at the back.		
5. Put on gown by slipping arms into sleeves.		
6. Slip fingers inside neck band.		
7. Tie neck tie in back or fasten strips.		
8. Grasp waist ties in front and bring to back.		
9. Reach behind and overlap edges of gown.		
10. Bring waist ties in front and tie.		
11. Don gloves.		
12. Complete client care.		
Removing gown: 13. Untie waist tie.		
14. Remove gloves and dispose in appropriate container in the room.		
15. Turn faucet on with clean paper towel.		
16. Wash and dry hands.		
17. Turn off faucet with clean, dry paper towel.		

18.	If wearing mask, remove mask holding it by ties only and discard in approved container.		
19.	Untie ties at neck, and loosen gown at neck.		
20.	Slip fingers of one hand inside the cuff of the other hand. NOTE: Do not touch the outside of the gown.		
21.	Pull gown down over hand.		
22.	With gown-covered hand, pull gown down over other hand.		
23.	Fold gown away from your body with contaminated side inward.		
24.	Roll gown into a ball.		
25.	Discard gown in proper receptacle.		
26.	Turn on faucet with clean paper towel.		
27.	Wash hands.		
28.	Turn off faucet with clean, dry paper towel.		
29.	Remove watch from clean side of paper towel.		
30.	If in isolation, open door with paper towel. Use toe to keep door open while disposing towel in trash receptacle before leaving client's room.		
31.	Wash hands.		

The student has satisfactorily completed the procedure "DON AND REMOVE GOWN" according to steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS: NAME OF STUDENT: ______________

DOUBLE BAG

EQUIPMENT:

1. Soiled linens or other items to be removed from the isolation room
2. 2 plastic bags
3. 2 ties

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
NOTE: Health care assistant in isolation room is gloved and if appropriate, gowned and masked.		
1. Call for assistance while in the isolation room.		
2. The person assisting will remain outside the isolation room.		
3. Place article into a plastic bag while inside the isolation room.		
4. Tie bag while in the isolation room.		
5. The person assisting should hold cuffed plastic bag outside the unit. Hands are protected by being under the cuff.		
6. Person inside isolation unit comes to the door and places contaminated bag into clean bag.		
7. Person assisting outside the room ties clean bag without touching the inside of the bag.		
8. Clean person discards bag in appropriate area.		

The student has satisfactorily completed the procedure "DOUBLE BAG" according to steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 14

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS: NAME OF STUDENT: ______________

COLLECT SPECIMEN IN ISOLATION ROOM

EQUIPMENT:

1. Specimen container
2. Paper towel
3. 2 plastic bags
4. 2 ties

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
NOTE: Health care assistant in isolation room is gloved and if appropriate gowned and masked.		
1. Lay a clean paper towel on the bedside stand.		
2. Place a clean specimen container on the paper towel.		
3. Place specimen in container without touching the container.		
4. Dispose of the receptacle in which the specimen was collected according to facility policy.		
5. Remove disposable gloves.		
6. Wash and dry hands.		
7. Put on a new pair of disposable gloves.		
8. Cover specimen and label container.		
9. Double bag specimen. Follow double bagging procedure.		

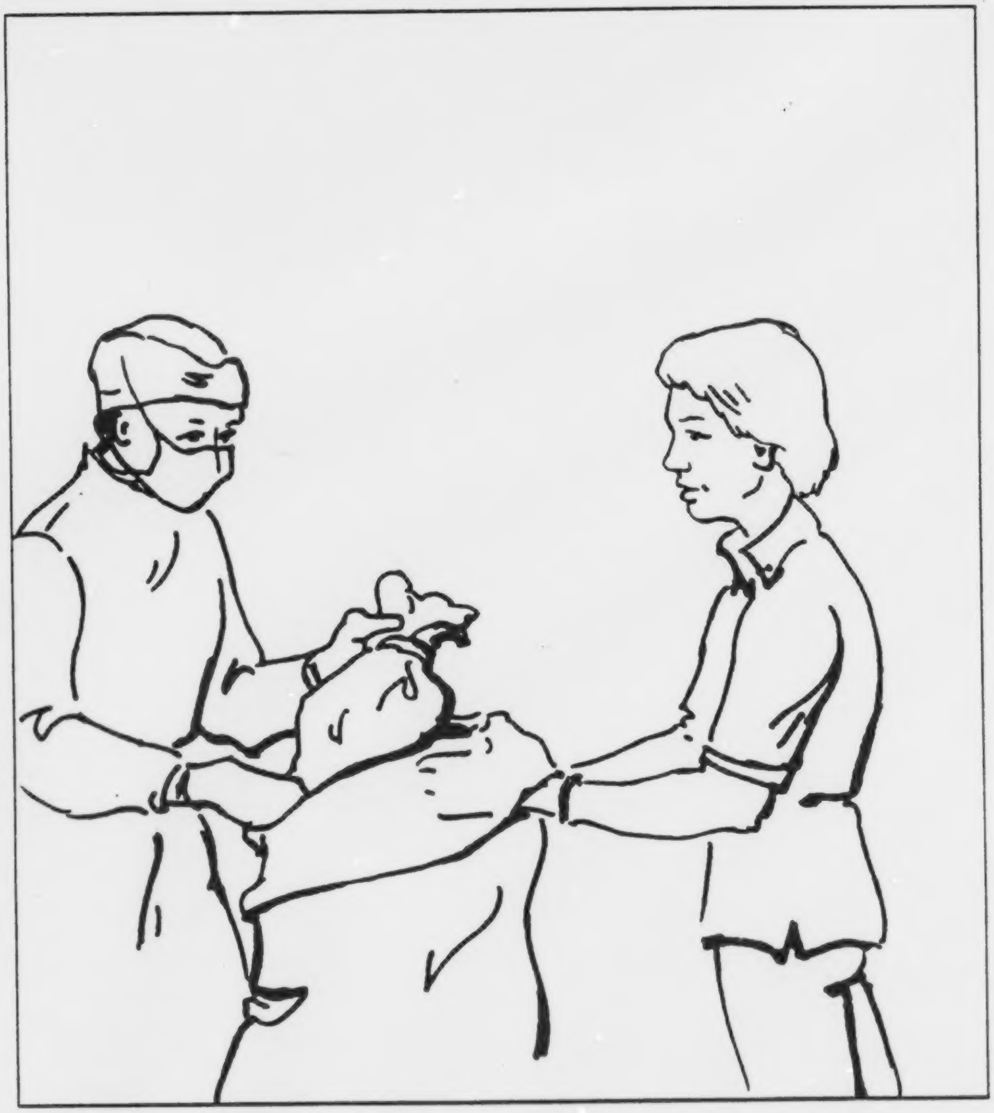
The student has satisfactorily completed the procedure "COLLECT SPECIMEN IN ISOLATION ROOM" according to steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

BEST COPY AVAILABLE

DOUBLE BAGGING



Double bagging technique for soiled or contaminated items.

LESSON PLAN: 15

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

SCOPE OF UNIT:

This unit covers an introduction to microorganisms, the prevention and control of infection, isolation, AIDS, and hepatitis.

INFORMATION TOPIC: IV-15 OR DEMONSTRATION:

ACQUIRED IMMUNODEFICIENCY SYNDROME AND THE HEALTH CARE WORKER

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms with the correct definition.
2. Describe acquired immunodeficiency syndrome (AIDS).
3. Describe the incubation period of AIDS.
4. Identify the cause of AIDS.
5. Name two tests used to diagnose AIDS.
6. Identify individuals at risk of contracting AIDS.
7. Identify symptoms of AIDS.
8. Describe the treatment for AIDS.
9. Explain how the AIDS virus is spread.
10. Describe misconceptions regarding transmission of the AIDS virus.
11. List ways to prevent getting AIDS.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: How the HIV Infection Attacks the Immune System
2. HO 2: AIDS Cases by Age

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 15 (Student Reference page 271) prior to class and be prepared to discuss the information presented.

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HIV/AIDS Newsletter. Missouri Department of Health, Bureau of AIDS Prevention, January-March 1993.

INTRODUCTION:

AIDS (acquired immunodeficiency syndrome) is the name given to a medical condition recognized in 1981 which affects the body's natural immunity against disease.

On December 6, 1991, the OSHA Bloodborne Pathogen Standards were issued to protect health care providers. The standards mandate engineering controls, work practices, and personal protective equipment that, coupled with employee training, will reduce on-the-job risks for all employees occupationally exposed to blood or other potentially infectious material. This lesson on AIDS will show you why these regulations are so important. It will also provide you with correct and up-to-date information about AIDS. AIDS is everyone's concern.

LESSON PLAN: 15

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

OUTLINE:

I. Terms and Definitions (HO 1) **(II-1)**

A. AIDS - acquired immunodeficiency syndrome: a condition characterized by the collapse of the body's natural immunity against disease

B. Immunity - resistance to a specific disease

C. Active immunity - that acquired by producing one's own antibody

D. Passive immunity - acquired by receiving antibody from a source other than one's own body - e.g. vaccines given for various communicable diseases

E. Immune deficiency - a lack of immune bodies and resultant impairment of the immune response to foreign agents (e.g., the body doesn't have enough white blood cells to fight off a disease or infection)

F. Leukocytes - white blood cells whose chief function is to protect the body against pathogenic microorganisms

G. Lymphocytes - a type of white blood cell. They are a product of lymphoid tissue and important in the development of immunity

H. HIV - means human immunodeficiency virus

I. OSHA - signifies the Occupational Safety and Health Administration

J. Parenteral - means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions

K. Asymptomatic - show no signs or symptoms of infection.

L. Incubation period - from the time of contact with a communicable disease until you come down with the first symptom of the disease.

M. Seropositive - antibodies to HIV appear in the blood stream.

N. Fatigue - extreme tiredness.

O. Mutation - changing of form to a new variety. A cell form changes from normal to abnormal.

P. Bisexual - homosexual and heterosexual relations

Q. Homosexual - characterized by sexual attraction felt by a person for another person of the same sex

R. Heterosexual - characterized by sexual attraction felt by a person for another person of the opposite sex

S. Semen - fluid secreted by the male testes; a male reproductive cell produced in the testes which is capable of uniting with an ovum and developing a new organism

T. Monogamous - having only one mate

U. Presumptive - something presumed as true

II. Description of Acquired Immunodeficiency Syndrome (AIDS)

A. AIDS is a relatively new disease. Even though there are several theories about the origin of the AIDS virus, the exact origin is not known.

B. AIDS is caused by a virus known as HIV (human immunodeficiency virus) **(II-2)**

C. An individual can be HIV infected but have no symptoms.

D. AIDS is a fatal disease with no known cure although much research is presently being done to find a cure.

E. AIDS is the last stage of an HIV infection.

III. Incubation Period

A. Incubation period is the period between contact with the virus and the start of symptoms and signs; the time may be as long as 16 years.

B. Most people become seropositive (show antibodies to HIV in the blood stream) approximately three months after infection. **(II-3)**

C. Usually the first six months to a year after exposure there are no signs or symptoms of the disease.

D. The asymptomatic period can last as long as seven to ten years, and some authorities say as long as 16 years.

IV. Cause

A. Caused by infection with the Human Immunodeficiency Virus (HIV)

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B. HIV is a human retrovirus. The virus enters the body, then infects a normal cell, causing an abnormal cell that can produce more viruses.

C. The HIV attacks and cripples an important type of T cell (lymphocyte - white blood cell), eventually destroying all of the T cells or T helpers. **(II-4)**

D. The individual's immune response is seriously impaired when the T cell (T helper or lymphocyte cell) is destroyed.

V. Diagnostic Tests

A. A blood test can detect the presence of antibodies to the HIV virus in the individual's blood stream. This test only indicates the person has been exposed to the HIV virus, not that he/she has the disease. **(II-5)**

1. ELISA - used to diagnosis HIV infection (positive is presumptive for AIDS)

2. Western blot - used to diagnose HIV infection (positive is confirming for AIDS).

VI. Individuals at Risk of Contacting AIDS **(II-6)**

A. People who have multiple sexual partners, male or female

B. People who have injected illegal drugs

C. People who have received blood transfusions or blood products prior to 1985

D. Infants born to infected mothers

VII. Symptoms of AIDS **(II-7)**

A. Dry cough

B. Loss of appetite

C. Weight loss greater than 10 pounds without dieting

D. Recurrent fever of 100°F

E. Drenching night sweats

F. Recurrent diarrhea

G. Fatigue - extreme or constant tiredness

H. Swollen lymph glands in the neck, underarms, and groin

I. Skin rashes - purple blotches or bumps on the skin that look like bruises but do not disappear

J. White spots in the mouth or on the tongue

K. Neurologic disorders

L. Opportunistic infections

1. Pneumonia - caused by the pneumocystis carinii, a protozoan

    a. The organism enters the lungs, multiplies and forms cyst packs that gradually occupy air space. The client gradually suffocates. It is contagious and there is no treatment.

2. Kaposi's sarcoma - a rare malignant disease. It produces tumors derived from skin and lymphoid tissue. The tumors are also found on internal organs.

VIII. Treatment

A. There is NO KNOWN cure for AIDS. (II-8)

B. There are some drugs given to improve the immune system's resistance to disease.

C. Stress reduction and imagery are used to assist the client with AIDS. Stress has an adverse effect on the immune system.

IX. How AIDS Is Spread (II-9)

A. By sexual contact (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum) with an infected person

B. By using needles or other injection equipment that an infected person has used (e.g., needles used by intravenous drug users, equipment used to tatoo or pierce ears)

C. By accidentally sticking yourself with a needle or other sharp used on an infected person

D. From an infected mother to her infant before or during birth and possibly through breast feeding

E. Receiving infected blood, blood products, or organs

NOTE: Since 1985 all donated blood has been tested to determine whether it is infected with the AIDS virus. The test cannot completely eliminate all infected blood. It is possible for someone to donate blood or plasma shortly after becoming infected with the AIDS virus, or before their blood has produced antibodies that can be found by current blood tests. Although the current blood test are highly accurate and the risk of contacting AIDS is extremely low, more specific tests are being developed to make blood and plasma products even safer.

F. Although no transmission from deep, open-mouth (i.e., French) kissing has been documented, such kissing theoretically could transmit the AIDS virus from an infected to an uninfected person through direct exposure of mucous membranes to infected blood.

X. Misconceptions Regarding Transmission of the AIDS Virus **(II-10)**

A common misconception regarding transmission of the AIDS virus is that it can be spread through casual contact. Studies have shown that AIDS cannot be spread by casual contact. The virus is NOT spread by any of the following methods:

A. Normal kissing

B. Shaking hands

C. Using public toilet seats

D. Drinking from water fountains

E. Mosquitos or other insects

F. Eating at the same table as an infected person

G. Hugging or touching an infected person

H. Eating food prepared by a person who has AIDS

I. Donating blood or having a blood test

J. Playing sports or games with persons with AIDS

K. Using public showers, bathrooms, or swimming pools

XI. Ways to Prevent Getting AIDS **(II-11)**

A. The risk of becoming infected with the AIDS virus can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.

B. Sexual transmission of the AIDS virus is not a threat to those uninfected individuals who engage in mutually monogamous sexual relations.

C. Using a latex condom for sexual activities is NOT 100% effective in preventing the spread of AIDS. A common spermicide, non-oxynol-9, has been known to kill the AIDS virus in laboratory tests.

D. In the health care field, wear gloves when it is likely that you will be in contact with blood or other potentially infectious diseases.

NOTE: MORE INFORMATION ABOUT AIDS CAN BE OBTAINED BY CONTACTING:

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF AIDS PREVENTION
P.O. BOX 570
JEFFERSON CITY, MO 65102

314/751-6438

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LESSON PLAN: 15

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

INTERACTION ITEMS:

1. What are the definition of terms presented in this lesson?
2. What pathogen causes AIDS?
3. When do most people show antibodies to HIV in the blood stream?
4. What is a T cell or T helper?
5. What diagnostic tests are done for AIDS?
6. What individuals are at risk of contacting AIDS?
7. What are the symptoms of AIDS?
8. What is the treatment for AIDS?
9. How is AIDS spread?
10. What are eight misconceptions regarding transmission of the AIDS virus?
11. How can you prevent getting AIDS?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. View one of the audiovisuals available through the AIDS Resource Center.

   Bureau of AIDS Prevention
   Missouri Department of Health
   P.O. Box 570
   Jefferson City MO 65102
   (314) 751-6438

2. Contact Missouri AIDS Speakers Bureau to schedule a speaker. Please contact:

   Al Schon, coordinator
   Missouri AIDS Network
   4050 Lindell Blvd.
   St. Louis, MO 63108
   (314) 658-2019 or (800) 245-2559

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3. Hold discussion on the possible psychosocial implications of the AIDS diagnosis for the client, the family, and the health care worker.

4. Have a class discussion on what the term "safe sex" means to students.

ANSWERS TO EVALUATION ITEMS:

1. c
2. f
3. g
4. a
5. b
6. e
7. b
8. a
9. T cell or T helper
10. c
11. d
12. c
13. c
14. a
15. Contact

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LESSON PLAN: 15

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I

____ 1. Immunity

____ 2. Leukocytes

____ 3. OSHA

____ 4. Lymphocytes

____ 5. AIDS

____ 6. Asymptomatic

Column II

a. A type of white blood cell important in the development of immunity

b. Acquired immunodeficiency syndrome

c. Resistance to a specific disease

d. That acquired by producing one's own antibody

e. Show no signs or symptoms of infection

f. White blood cells whose chief function is to protect the body against pathogenic organisms

g. Signifies the occupational safety and health administration

7. Which one of the following is a true statement describing acquired immunodeficiency syndrome (AIDS): (Circle the letter of the best answer.)

   a. AIDS is a very old disease.
   b. AIDS is caused by a virus known as HIV.
   c. An HIV infected person always has symptoms.
   d. AIDS is not always a fatal disease.

8. The incubation period for AIDS is: (Circle the letter of the best answer.)

   a. Most people show antibodies to HIV in the blood stream three months after infection.
   b. Most people show antibodies to HIV in the blood stream immediately after infection.
   c. Most people do not show antibodies to HIV in the blood stream for 16 years.
   d. Most people do not show antibodies to HIV in the blood stream for 10 years.

9. The HIV retrovirus attacks and cripples an important cell called the ______________________________.

10. Two diagnostic tests for AIDS are: (Circle the letter of the best answer.)

    a. EMMA and Southern Blot.
    b. ERMA and Eastern Blot.
    c. ELISA and Western Blot.
    d. Elizabeth and Midwest Blot.

11. Which of the following individuals have the highest risk of contacting AIDS? (Circle the letter of the best answer.)

    a. Individuals in a monogamous relationship
    b. Individuals who abstain from intercourse
    c. Individuals who care for AIDS clients
    d. Individuals who have sexual relations with many partners

12. Symptoms of AIDS include all of the following except: (Circle the letter of the best answer.)

    a. Weight loss greater than 10 pounds without dieting.
    b. Swollen lymph glands in the neck, underarms, and groin.
    c. Constipation and productive cough.
    d. Drenching night sweats and recurrent diarrhea.

13. Which one of the following is true concerning the treatment of AIDS: (Circle the letter of the best answer.)

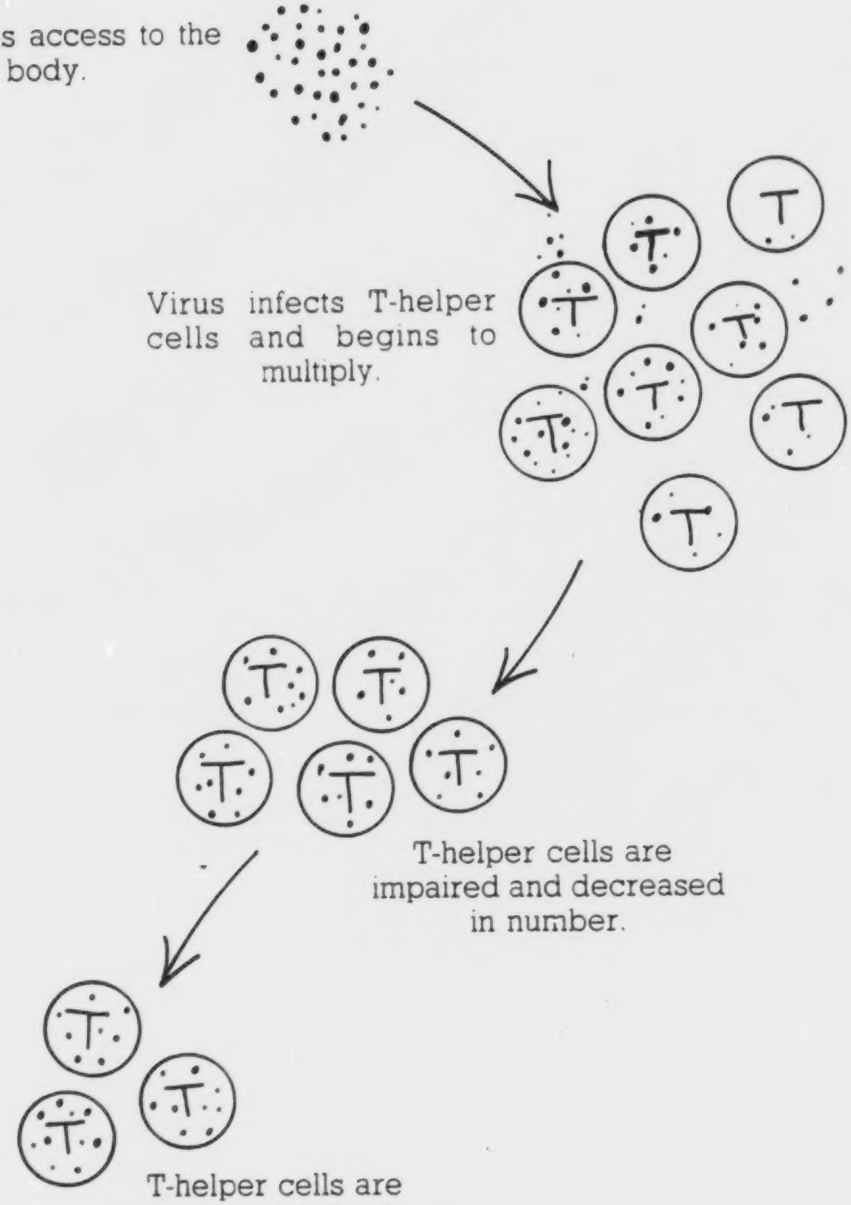
    a. AIDS can be cured if treated early.
    b. Antibiotics will cure aids.
    c. There is no known cure for AIDS.
    d. Vitamins have been known to cure AIDS.

14. The AIDS virus is spread by: (Circle the letter of the best answer.)

    a. Vaginal fluid, blood, and semen.
    b. Shaking hands.
    c. Water fountains.
    d. Toilet seats.

15. A common misconception regarding the transmission of the AIDS virus is that it can be spread through casual ________________.

HOW THE HIV INFECTION ATTACKS THE IMMUNE SYSTEM



HIV gains access to the body.

Virus infects T-helper cells and begins to multiply.

T-helper cells are impaired and decreased in number.

T-helper cells are reduced and body is more susceptible to all infections.

AIDS CASES BY AGE*

AGE GROUP	MISSOURI		UNITED STATES	
	CASES	(%)	CASES	(%)
<13	29	0.90%	4,249	1.68%
13-19	29	0.90%	946	0.37%
20-29	801**	24.92%	48,295	19.06%
30-39	1,425	44.34%	115,918	45.74%
40-49	636	19.79%	57,987	22.88%
>49	294	9.15%	26,053	10.28%
TOTAL	**3,214**	**100.00%**	**253,448**	**100.00%**

*NOTE: Reported cases through 1992

**NOTE: Many of the individuals diagnosed with AIDS in their 20's were likely infected with HIV while teenagers.

Credit: HIV/AIDS Newsletter. Missouri Department of Health, Bureau of AIDS Prevention, January-March 1993.

LESSON PLAN: 16

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV: CONCEPTS OF MICROBIOLOGY

SCOPE OF UNIT:

This unit covers an introduction to microorganisms, the prevention and control of infection, isolation and AIDS, and hepatitis.

INFORMATION TOPIC: IV-16 OR DEMONSTRATION:

HEPATITIS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe viral hepatitis.
2. List the three types of hepatitis.
3. Identify how hepatitis is spread.
4. List the incubation period for hepatitis A, hepatitis B, and non-A, non-B hepatitis.
5. Describe the symptoms of hepatitis.
6. Describe the prognosis of hepatitis.
7. Identify measures to prevent hepatitis.
8. Describe treatment for hepatitis.
9. Describe your rights as an employee if you are exposed to hepatitis.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Hepatitis A Fact Sheet
2. HO 2: Hepatitis B Fact Sheet

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 16 (Student Reference page 281) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Schere, Jeanne C. Introductory Medical-Surgical Nursing. 4th ed. Philadelphia: PA, J.B. Lippencott, 1992, Chapter 38.

Burhoe, Steven. Bloodborne Pathogens, An Overview of OSHA's Standards. University of Missouri-Columbia, Instructional Materials Laboratory, 1992.

Missouri Department of Health, P.O. Box 570, Jefferson City, MO 65102.

INTRODUCTION:

Viral hepatitis is a very contagious disease. As a health care assistant, proper handwashing is vital in preventing the spread of hepatitis.

LESSON PLAN: 16

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

OUTLINE:

I. Viral Hepatitis

   A. An infectious contagious disease of the liver caused by a virus. The liver cells may die. Damage to the liver may prevent normal bile secretions.

II. Types of Hepatitis

   A. Caused by the hepatitis A virus (HAV). Also known as infectious hepatitis or epidemic hepatitis.

   B. Hepatitis B - caused by the hepatitis B (HBV). Also known as serum hepatitis.

   C. Non-A, non-B (NANB) hepatitis - a form of hepatitis not caused by the hepatitis A virus or hepatitis B virus.

III. Transmission

   A. Hepatitis A - from person to person by contact with the virus in the:

      1. Feces and saliva of infected person

      2. Blood of the infected person

      3. Water

      4. Food contaminated with the virus from diseased food handlers, cooks or waiters

      5. Contaminated rectal thermometers, bedpans, and linens

   B. Hepatitis B

      1. Transfusions of blood or plasma

      2. Needles, syringes, surgical or dental equipment

      3. Intimate contact with carriers or those who have the disease. The virus is found in:

         a. Vaginal secretions

        - b. Semen
        - c. Saliva
    - C. Non-A, non-B hepatitis
        - 1. Believed to be transmitted by:
            - a. Blood of infected person by means of transfusions of blood or blood products or by contaminated needles, syringes, or surgical or dental equipment.

        CAUTION: You do not have to be stuck by a contaminated needle or have a break in the skin to contact hepatitis. The virus can enter the body through the mucous membranes of the eye, nose, and mouth.

- IV. Incubation Period
    - A. Hepatitis A - 3 to 5 weeks
    - B. Hepatitis B - 2 to 5 months
    - C. Non-A, non-B hepatitis - Average 7 weeks
- V. Signs and symptoms - flu-like symptoms
    - A. Nausea and vomiting
    - B. Low grade or high fever
    - C. Malaise (a feeling of discomfort or uneasiness)
    - D. Headache
    - E. Right upper quadrant discomfort
    - F. Enlargement of the spleen, liver, and lymph nodes
    - G. Weight loss
    - H. Rash
    - I. Pruritus (itching)
    - J. Jaundice (yellow color of skin)
    - K. Clay-colored or light-colored stools
    - L. Dark-colored urine

- M. Extreme fatigue
- N. Anorexia (loss of appetite)

VI. Prognosis (outcome of the disease)

- A. Fewer than 1% of people with hepatitis will die.
- B. Those who recover can never be blood donors.
- C. A few will have chronic active hepatitis.

VII. Prevention - Follow OSHA Standards for Bloodborne Pathogens and Universal Precautions

- A. Immune globulin (gamma globulin) can be given before or after exposure to hepatitis A.
- B. Immune globulin is given for those exposed to hepatitis B. This is the vaccine indicated for health care providers.
- C. Scrupulous handwashing is required.
- D. Wear gloves when handling body fluids and feces.
- E. Follow needle precautions.
- F. Maintain safe water and food supplies.
- G. Screening of blood donors prevents contaminated blood from entering the blood bank.
- H. Use disposable needles and syringes.
- I. Follow Body Substance Precautions for handling of needles and syringes.

VIII. Treatment **(II-7)**

- A. There is no drug or medical treatment.
- B. During the acute phase, bed rest is prescribed.
- C. High protein, high carbohydrate diet is recommended.

IX. Your Rights - Hepatitis B Exposure **(II-8)**

- A. If you have occupational exposure to blood or potentially infectious materials in your position, your employer must make available the hepatitis B vaccine and vaccination series, and post-evaluation follow-up to all employees who have had an exposure incident. The vaccination, and follow-up are to be at no cost to the employee be performed by a licensed physician or licensed health professional within a reasonable time and place, and be provided according to the recommendations of the U.S. public health.

B. After receiving training for a position with occupational exposure, within 10 working days your employer must make the vaccine series available. Only those who have previously had the series, are immune by antibody testing, or for those who the vaccine is contraindicated for medical reason need not have the vaccine offered to them.

C. Participation in a prescreening program cannot be required by the employer as a prerequisite for receiving the HBV vaccine. Employees refusing the vaccine must sign a statement refusing to participate in the vaccination offer. They can reverse their decision later.

X. Summary and Conclusion

A. Viral hepatitis

B. Types of hepatitis

C. Incubation period

D. Signs and symptoms

E. Prognosis

F. Prevention

G. Treatment

H. Your rights - hepatitis B exposure

Hepatitis is a hazard to all health care providers. Immunization is highly recommended for all health care providers.

LESSON PLAN: 16

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

INTERACTION ITEMS:

1. What is viral hepatitis?
2. What are the three types of hepatitis?
3. What is the incubation period for hepatitis A, B, and non-A, non-B?
4. How many symptoms of hepatitis can you recall?
5. What is the prognosis of an individual who has hepatitis?
6. What measures prevent hepatitis?
7. What is the treatment for hepatitis?
8. What are your rights as an employee if you are exposed to hepatitis?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have the class make a poster listing Body Substance Precautions.
2. Melt a chocolate candy bar in a bedpan. Have students dispose of it as if it were feces from a client with hepatitis.

ANSWERS TO EVALUATION ITEMS:

1. Virus
2. Hepatitis A
   Hepatitis B
   non-A, non-B
3. d
4. 3-5 weeks
   2-5 months
   average 7 weeks
5. Blood donors
6. b
7. Treatment
8. Cost

LESSON PLAN: 16

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IV : CONCEPTS OF MICROBIOLOGY

EVALUATION ITEMS:

1. Viral hepatitis is an infectious, contagious disease of the liver caused by a ____________________.

2. List the three types of hepatitis.

   a.

   b.

   c.

3. Which of the following is NOT a true statement concerning the transmission of hepatitis? (Circle the letter of the best answer.)

   a. Non-A, non-B can be transmitted through contaminated needles.
   b. Hepatitis A can be transmitted through food contaminated with the virus.
   c. Hepatitis A can be transmitted through water.
   d. Hepatitis B can only be transmitted through blood transfusions.

4. List the incubation period for:

   a. Hepatitis A ____________________

   b. Hepatitis B ____________________

   c. Non-A, non-B hepatitis ____________________

5. Individuals who recover from hepatitis can never be ____________________.

6. Hepatitis can be prevented by: (Circle the letter of the best answer.)

   a. Sterilizing needles and syringes after use.
   b. Scrupulous handwashing.
   c. Wearing sterile gloves.
   d. Not eating in fast food restaurants.

7. For hepatitis there is no drug or medical ____________________.

8. If you are employed and exposed to the hepatitis virus, your employer must make available the vaccine to you at no ____________________.

HEPATITIS A FACT SHEET

What is hepatitis A?

Hepatitis A (formerly known as infectious hepatitis) is a liver disease caused by a specific virus. The disease is fairly common; from 100 to 900 cases are reported in Missouri each year.

Who gets hepatitis A?

Anyone can get hepatitis A, but it occurs more frequently in children.

How is the virus spread?

The hepatitis A virus enters through the mouth, multiplies in the body and is passed in the feces. The virus can then be carried on an infected person's hands and can be spread by direct contact, or by consuming food or drink that has been handled by the individual. In some cases, it can be spread by consuming water contaminated with improperly treated sewage. An increasing number of hepatitis A cases have been reported in drug abusers, and it is suspected that contaminated drugs or close personal contact is the cause.

What are the symptoms of hepatitis A?

The symptoms of hepatitis A may include fatigue, poor appetite, fever, and vomiting. Urine may become darker in color, and then jaundice (a yellowing of the skin and/or whites of the eyes) may appear. The disease is rarely fatal and most people recover in a few weeks without any complications. Infants and young children tend to have very mild symptoms and are less likely to develop jaundice than are older children and adults. Not everyone who is infected will have all of the symptoms.

How soon do symptoms appear?

The symptoms may appear two or seven weeks after exposure, but usually four to five weeks.

How is it diagnosed?

Since there are several types of viral hepatitis, a blood test is needed to determine which type of hepatitis is present.

For how long is an infected person able to spread the virus?

The contagious period begins approximately two weeks before the symptoms appear, and extends one week after the appearance of jaundice. If jaundice is not present, the person should be considered infectious for two weeks following the onset of symptoms.

Does past infection with hepatitis A make a person immune?

Once an individual recovers from hepatitis A, he or she is immune for life and does not continue to carry the virus.

What is the treatment for hepatitis A?

There are no special medicines or antibiotics that can be used to treat a person once the symptoms appear. Generally, rest and supportive treatment are all that is needed.

How can hepatitis A be prevented?

A vaccine is not currently available. The single most effective way to prevent spread is careful handwashing after using the toilet or changing diapers. Also, infected people should not handle foods during the contagious period. Household members or others in close contact with an infected person should call a doctor or the health department to obtain a shot of immune globulin which minimizes their chances of becoming ill. Immune globulin must be given within two weeks of exposure to be effective.

Credit: Missouri Department of Health, P.O. Box 570, Jefferson City, MO 65102.

HEPATITIS B FACT SHEET

What is hepatitis B?

Hepatitis B (formerly known as serum hepatitis) is a liver disease caused by a virus. The disease is fairly common; more than 500 cases were reported in Missouri in 1991.

Who gets hepatitis B?

Anyone can get hepatitis B, but those at greatest risk include:

- babies born to mothers who are infected with the hepatitis B virus (including carriers);
- drug abusers who share needles;
- persons in occupations where there is contact with infected blood and body fluids;
- sexually active homosexual and bisexual men;
- sexually active heterosexual men and women (sexual activity with more than one partner in the previous 6 months);
- men and women who have a recent diagnosis of another sexually transmitted disease;
- people in custodial care (in settings such as centers for the developmentally disabled);
- hemodialysis patients;
- persons who receive unscreened blood products;
- certain household contacts of an infected person;
- household contacts and sexual partners of hepatitis B carriers;
- inmates of long-term correctional facilities;
- persons from countries where hepatitis B is widespread (certain areas of Asia and Africa);
- persons in the United States who are Alaskan Natives or Pacific Islanders.

How is the virus spread?

Hepatitis B virus can be found in the blood of infected persons; it is also present in lesser amounts in saliva, semen, and other body fluids. Although saliva can contain small amounts of the hepatitis B virus, it is not usually spread in this way. It is spread by direct contact with infected body fluids, usually by needle sharing, needle stick injury, or sexual contact. Hepatitis B virus is not spread by casual contact.

What are the symptoms of hepatitis B?

Some people have loss of appetite, tiredness, fever, vomiting and occasionally joint pain, hives, or rash. Urine may become darker in color, and then jaundice (a yellowing of the skin and whites of the eyes) may appear. Some people have no symptoms or only a few symptoms.

How soon do symptoms appear?

The symptoms appear two to six months after exposure, but usually within three months.

How is hepatitis B diagnosed?

Since there are several types of viral hepatitis, a blood test is needed to determine which type of hepatitis is present.

For how long is a person able to spread the virus?

The virus can be found in blood and other body fluids several weeks before symptoms appear and generally for several months afterward. About 1 in 10 people with hepatitis B will go on to become carriers of the virus; they can continue to spread the virus even if they do not have symptoms.

What is the treatment for hepatitis B?

There are no special medicines or antibiotics that can be used to treat a person once the symptoms appear. Generally, rest and supportive treatment are all that is needed. Carriers who have chronic hepatitis B infection may benefit from treatment with a medication called interferon alfa-2b.

What precautions should hepatitis B carriers take?

Hepatitis B carriers should practice good hygiene so that close contacts are not directly exposed to their blood or other body fluids. Carriers must not share razors, toothbrushes, or any other object that may become contaminated with blood. In addition, household members, particularly sexual partners, should be immunized with hepatitis B vaccine. Carriers should practice "safer sex" if their partners are not immunized. It is important for carriers to inform their dentists and other health care providers of their carrier state.

How can hepatitis B be prevented?

A vaccine to prevent hepatitis B has been available for several years. It is safe, effective and is recommended for all newborns and for people at high-risk who have not already been infected (see previous page 1, "Who gets hepatitis B?"). A special hepatitis B immune globulin (HBIG) is also available for people who are exposed to the virus. If you are exposed to hepatitis B, consult a doctor or your local health department.

Credit: Missouri Department of Health, P.O. Box 570, Jefferson City, MO 65102.

LESSON PLAN: 17

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

SCOPE OF UNIT:

This unit introduces the body as a whole, its organizational structure and the terminology associated with it.

INFORMATION TOPIC: V-17 OR DEMONSTRATION:

THE BODY AS A WHOLE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe anatomical position.
2. Identify body planes on a diagram.
3. Match directional terms to correct definitions.
4. Apply correct directional terms related to body parts.
5. List the two major body cavities, the subdivision in each, and the major organs in each.
6. Identify regions of the abdomen.
7. Identify quadrants of the abdomen.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Anatomical Position
2. HO 2: Body Planes
3. HO 3: Directional Terms
4. HO 4: Body Cavities
5. HO 5: Regions of the Abdomen
6. HO 6: Quadrants of the Abdomen

7. Wall charts of human body

8. Anatomical model (entire body) - standard tool

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 17 (Student Reference page 291) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Ester G. Skelley. Body Structure and Function, 7th ed. Albany, NY: Delmar Publishers, 1989.

Anthony, Catherine; Gary Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Times Mirro/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

In this lesson we will study directional terms and body regions used frequently in the health care field to describe the position of one body part in relation to another.

LESSON PLAN: 17

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

OUTLINE:

I. Anatomical Position (HO 1) - Used to describe the human body when standing. Body is erect, face forward with arms at sides and palms turned forward. **(II-1)**

II. Body Planes (HO 2) **(II-2)**

  A. Sagittal - divides body into right and left sides

  B. Frontal - divides body into front and back

  C. Transverse - divides body into top and bottom

III. Directional Terms (HO 3) **(II-3)**

  A. Superior - toward the head end or the upper part of body

  B. Inferior - away from the head end or toward the lower part of body

  C. Medial - closer to the midline of the body

  D. Lateral - toward the side of body or away from midline

  E. Proximal - nearer a point of reference, usually the trunk or middle of the body

  F. Distal - farther away from a point of reference, usually the trunk or middle of the body

  G. Anterior (ventral) - the front or in "front of"

  H. Posterior (dorsal) - the back side of the body

  I. Cranial - the head end of the body

  J. Caudal - the tail end of the body

IV. Body Cavities (HO 4) **(II-4)**

  A. Dorsal (posterior) - refers to the back **(II-5)**

    1. Cranial - contains brain

    2. Spinal - contains spinal cord

B. Ventral (Anterior) - refers to the front **(II-6, 7, 8)**

  1. Thoracic - contains lungs, heart
  2. Abdominal - contains stomach, intestines
  3. Pelvic - contains bladder and some reproductive organs

V. Regions of the Abdomen (HO 5) **(II-9)**

  A. Right hypochondriac
  B. Left hypochondriac
  C. Epigastric
  D. Umbilical
  E. Right lumbar
  F. Left lumbar
  G. Right iliac
  H. Left iliac
  I. Hypogastric

VI. Quadrants of the Abdomen (HO 6) **(II-10)**

  A. Right upper quadrant
  B. Right lower quadrant
  C. Left upper quadrant
  D. Left lower quadrant

VII. Summary and Conclusion

  A. Anatomical position
  B. Body planes
  C. Directional terms
  D. Body cavities
  E. Regions of the abdomen

F. Quadrants of the abdomen

In the next lesson, we will look at the organization of the body beginning with the single cell. Be sure to study the handout and read the informational assignment beforehand.

LESSON PLAN: 17

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

INTERACTION ITEMS:

1. What is the anatomical position?
2. Where are the sagittal, frontal, and transverse body planes located?
3. How are the directional terms defined in relation to the human body?
4. What are the two main body cavities?
5. What organs are contained in the dorsal cavity?
6. What is the name of the body cavity that most people think of as their chest?
7. What body cavity contains the stomach and intestines?
8. What body cavity contains the bladder and reproductive organs?
9. What are the nine regions of the abdomen?
10. Where are the four (4) quadrants of the abdomen located?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Discuss the handouts included with this lesson and in conjunction with the classroom anatomical model.
2. Have students describe parts of their bodies using directional terms.

ANSWERS TO EVALUATION ITEMS:

1. Anatomical
2. g
3. a
4. d
5. c
6. b
7. h
8. e
9. f
10. Inferior

11. Superior
12. Ventral
13. Medial
14. Lateral
15. Transverse
16. Sagittal
17. Frontal

18. a. Dorsal
    1. Cranial
    2. Spinal
  b. Ventral
    1. Thoracic
    2. Abdominal
    3. Pelvic

19. a. Right hypochondriac
  b. Epigastric
  c. Left hypochondriac
  d. Right lumbar
  e. Umbilical
  f. Left lumbar
  g. Right iliac
  h. Hypogastric
  i. Left iliac

20. a. Right upper quadrant
  b. Left upper quadrant
  c. Right lower quadrant
  d. Left lower quadrant

LESSON PLAN: 17
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT V : CONCEPTS OF THE BODY AS A WHOLE

EVALUATION ITEMS:

1. ____________ position is a term used to describe the body when erect with the arms at the sides, face forward and palms turned upward.

Match the following directional terms in Column II to the correct definitions in Column I.

Column I

___ 2. Toward the head end or the upper part of body

___ 3. Toward the side of body or away from midline

___ 4. Farther away from a point of reference

___ 5. Closer to the midline of the body

___ 6. Nearer a point of reference, usually the trunk or middle of the body

___ 7. The back side of the body

___ 8. The front or "belly side" of the body

___ 9. Away from the head or toward the lower part of the body

Column II

a. Lateral
b. Proximal
c. Medial
d. Distal
e. Anterior
f. Inferior
g. Superior
h. Posterior

Fill in the blank with the correct directional term.

10. The ankle is ____________ to the thigh.

11. The thigh is ____________ to the ankle.

12. The knee cap is anterior or ______________.

13. The little finger is ____________ to the trunk.

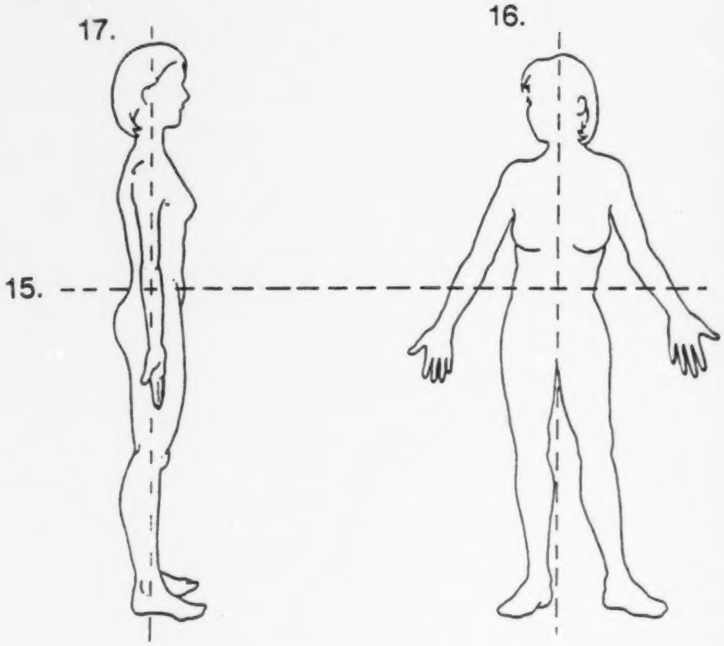
14. The thumb is ______________ to the trunk.

Identify body planes on the following diagram.

15.

16.

17.



18. List the body cavities and their subdivisions.

    a.

        1.

        2.

    b.

        1.

        2.

        3.

19. Name the regions of the abdomen shown on the diagram

a.

b.

c.

d.

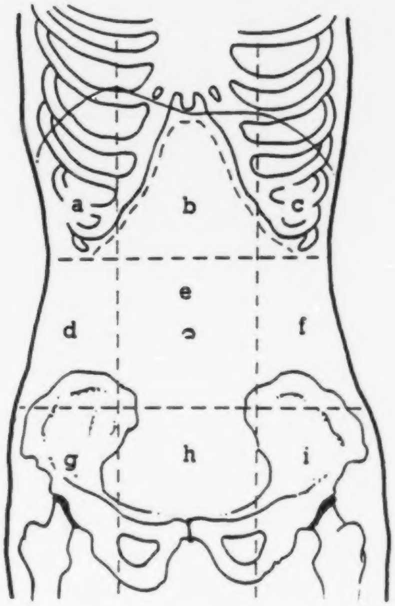
e.

f.

g.

h.

i.



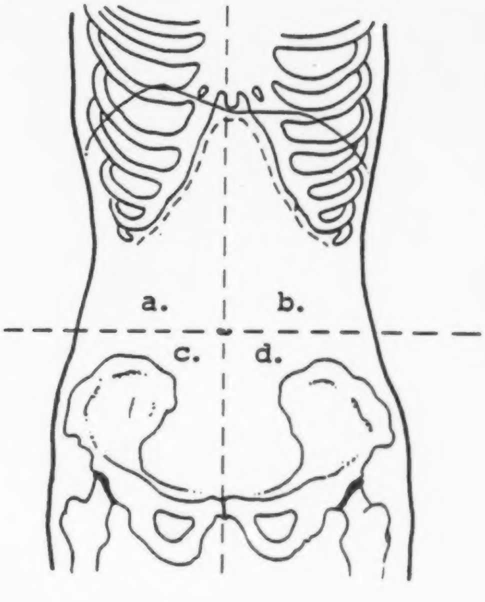
20. Name the quadrants of the abdomen shown on the diagram.

a.

b.

c.

d.



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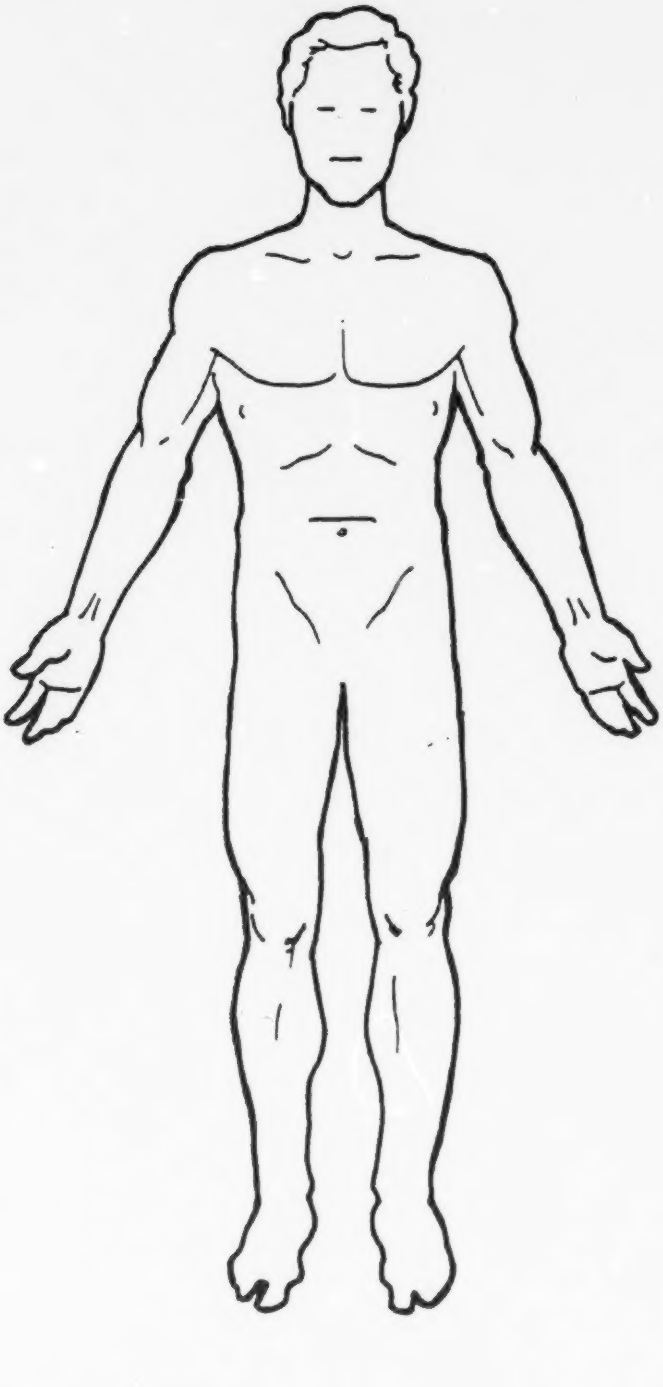
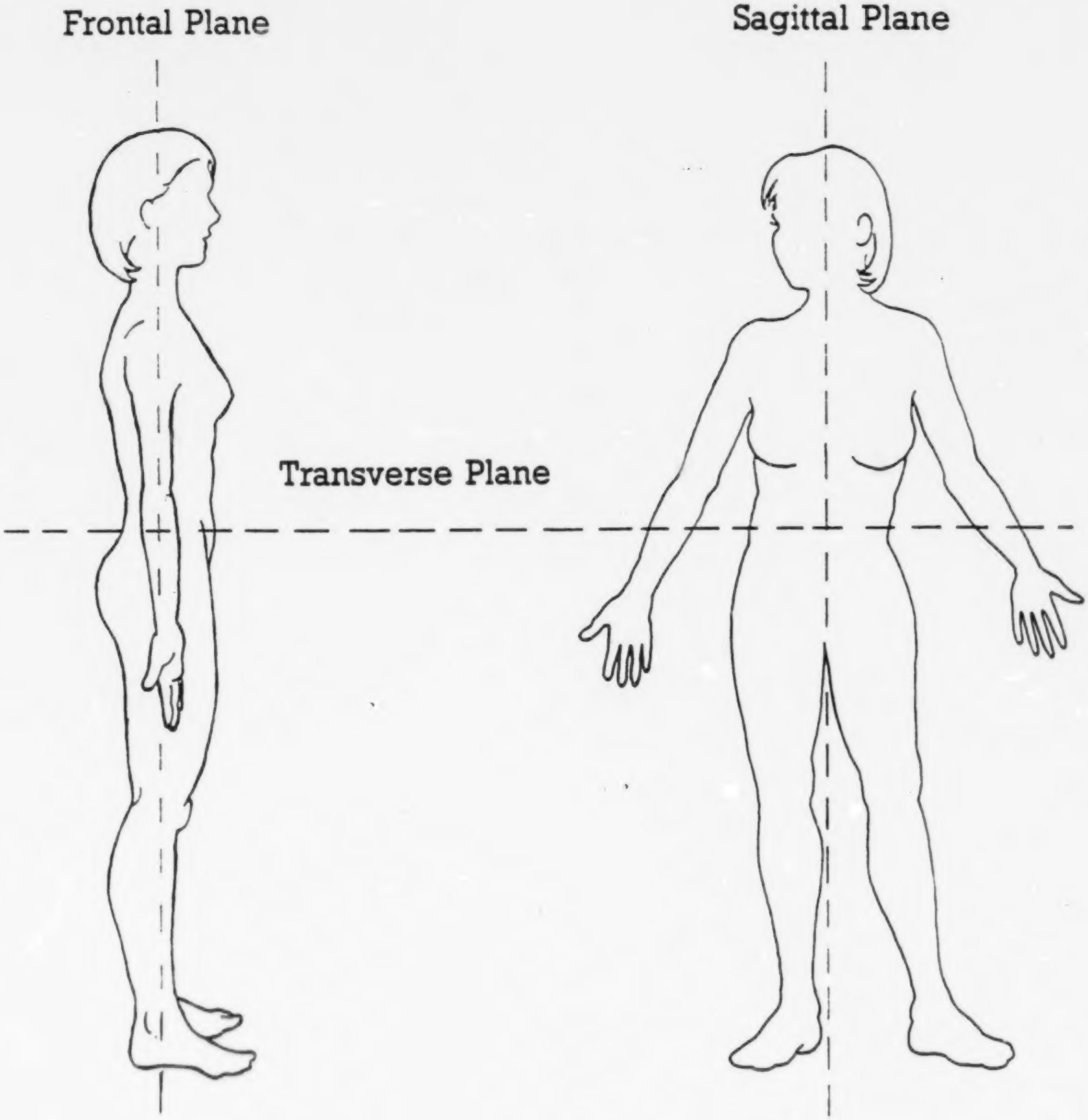
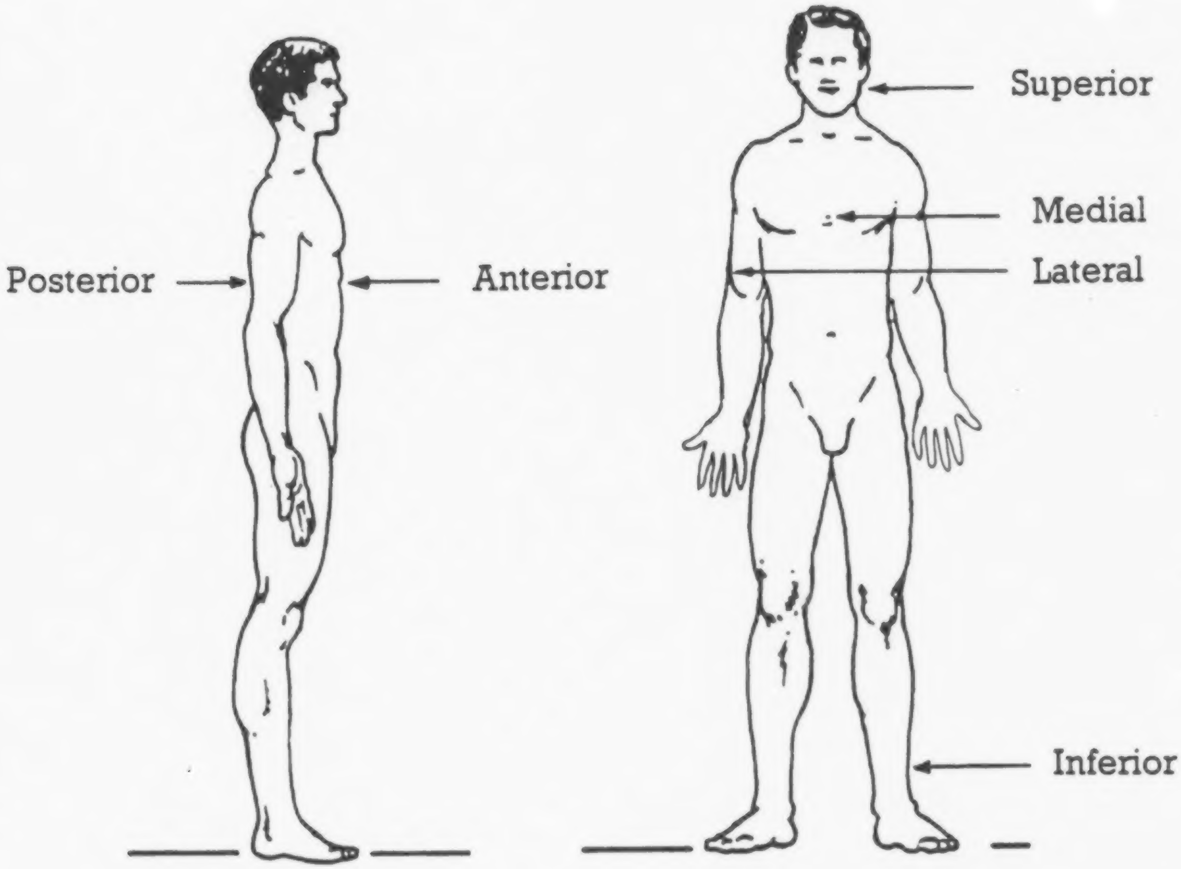
ANATOMICAL POSITION

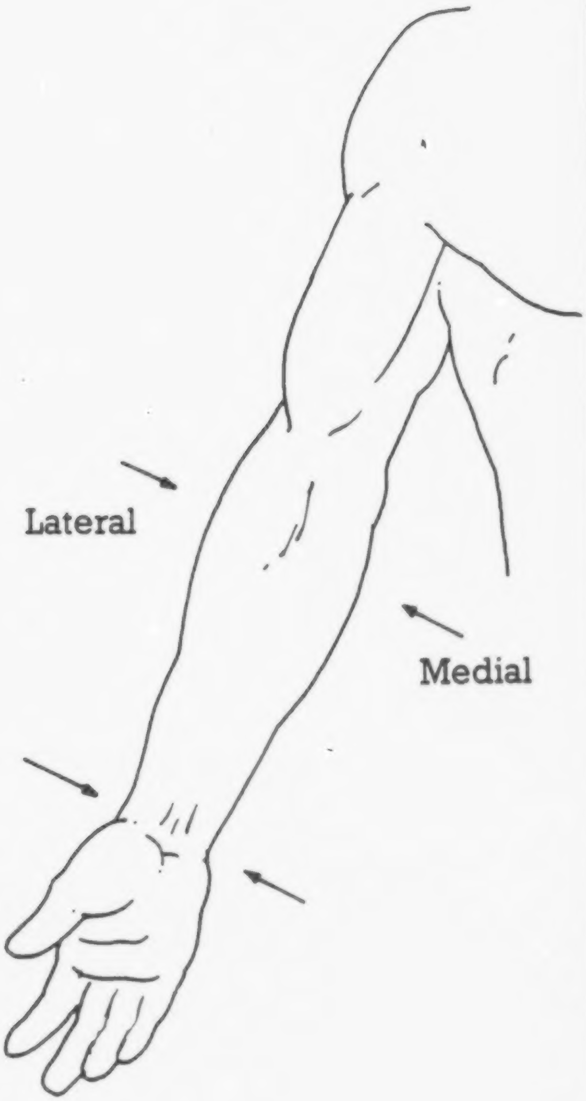


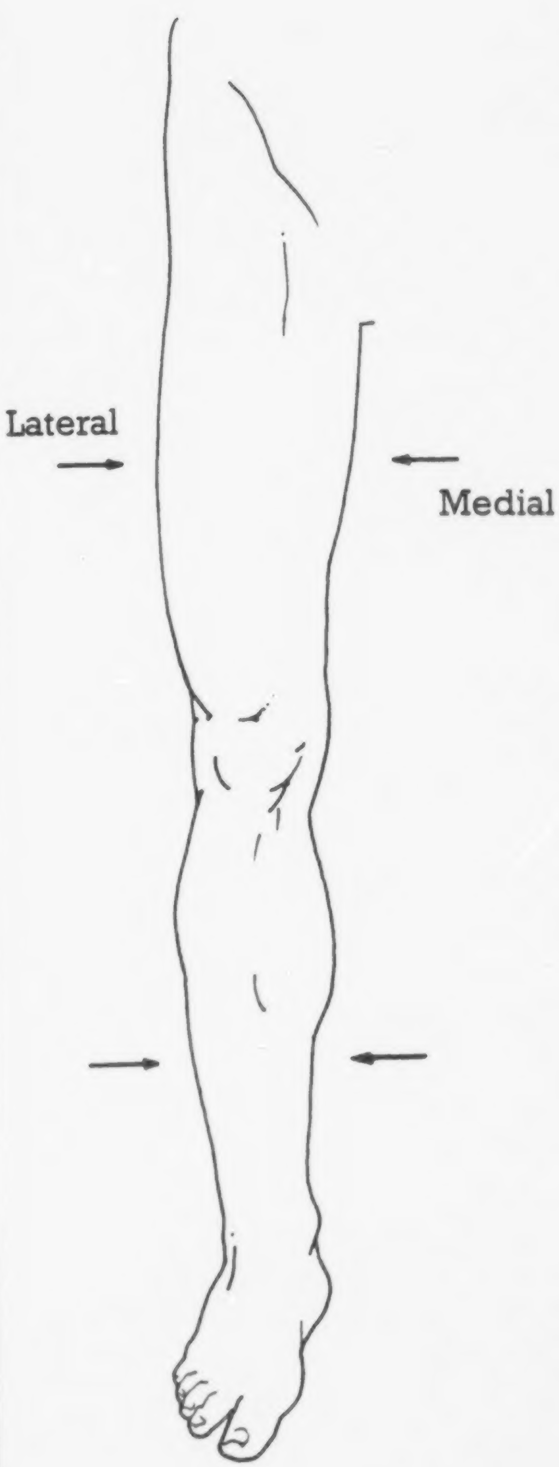
BODY PLANES


Frontal Plane
Sagittal Plane
Transverse Plane

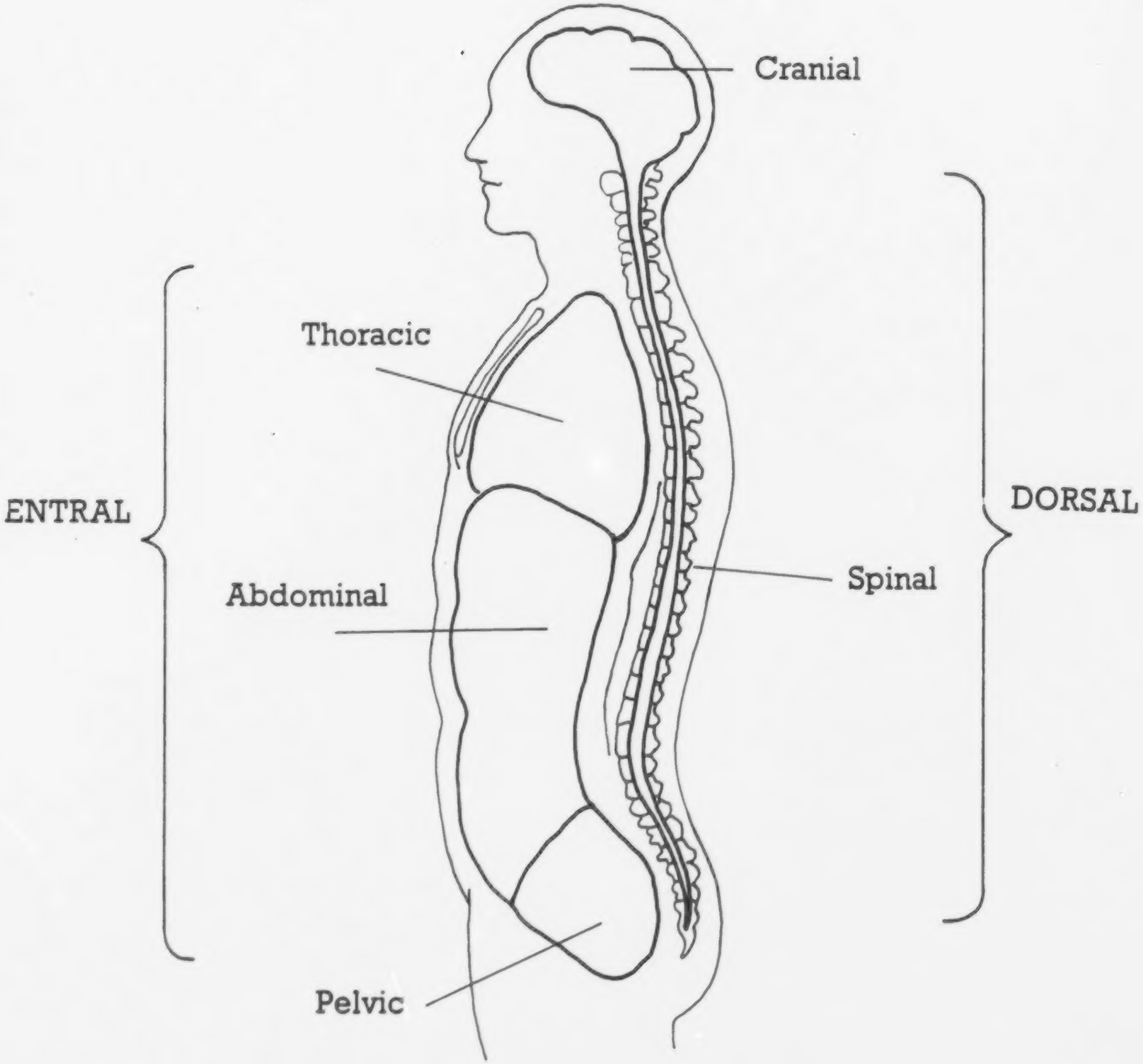
DIRECTIONAL TERMS


Posterior
Anterior
Superior
Medial
Lateral
Inferior

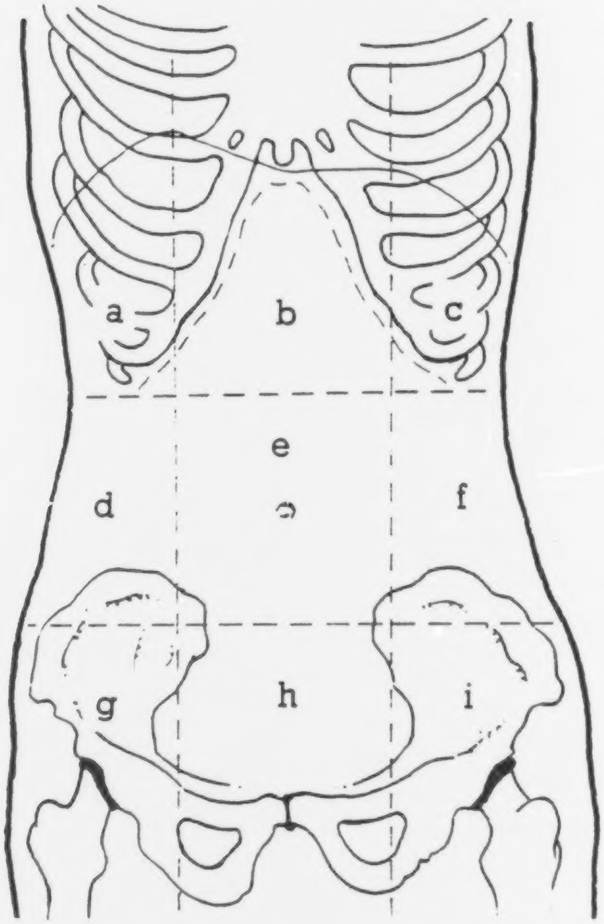

Lateral
Medial


Lateral
Medial

BODY CAVITIES

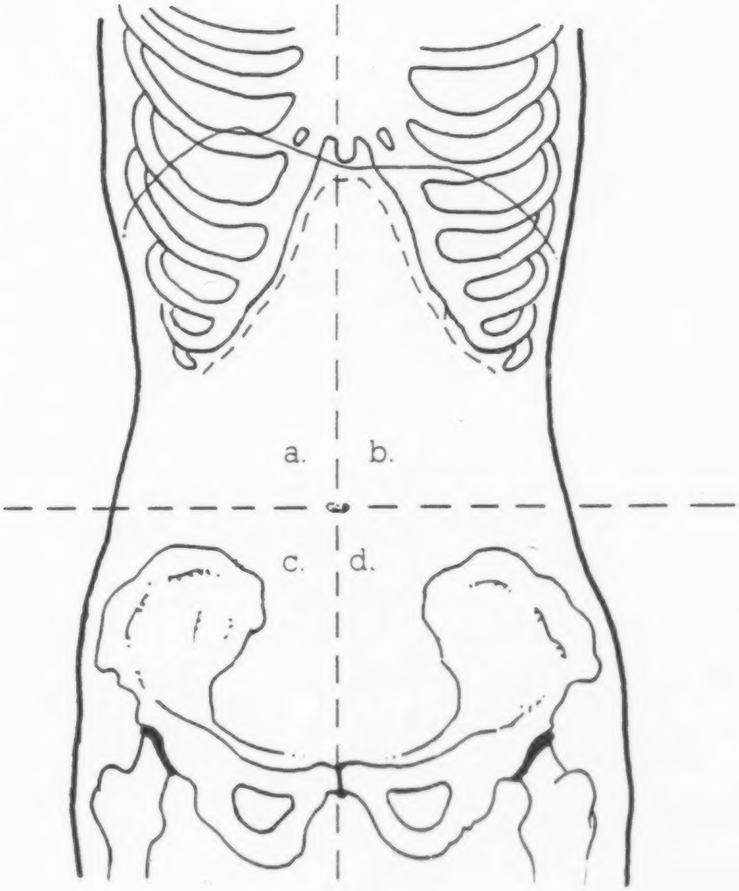

Cranial
Thoracic
ENTRAL
Abdominal
Pelvic
DORSAL
Spinal

REGIONS OF THE ABDOMEN



a. Right Hypochondriac	f. Left Lumbar
b. Epigastric	g. Right Iliac
c. Left Hypochondriac	h. Hypogastric
d. Right Lumbar	i. Left Iliac
e. Umbilical	

QUADRANTS OF THE ABDOMEN



a. Right Upper Quadrant
b. Left Upper Quadrant
c. Right Lower Quadrant
d. Left Lower Quadrant

LESSON PLAN: 18

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

SCOPE OF UNIT:

This unit introduces the body as a whole, its organizational structure, and the terminology associated with it.

INFORMATION TOPIC: V-18 OR DEMONSTRATION:

ORGANIZATION OF THE BODY
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with their correct definitions.
2. List five functions of a cell.
3. Label parts of a cell.
4. List four basic types of body tissues.
5. Match the four types of body membranes with their functions.
6. Describe an organ.
7. Describe a body system.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Cell

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 18 (Student Reference page 307) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Ester G. Skelley. Body Structure and Function, 7th ed. Albany, NY: Delmar Publishers, 1989.

Anthony, Catherine; Gary Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Times Mirro/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

As we begin our study of the structure and function of the human body we become aware of its marvelous workings and learn to appreciate our bodies. It is necessary to be familiar with the normal body in order to recognize deviations.

LESSON PLAN: 18

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

OUTLINE:

I. Terms and Definitions (II-1)

  A. Anatomy - the study of the shape and structure of the body

  B. Cytology - the study of cells, their origin, structure, and functions

  C. Diffusion - movement of particles through a cell membrane, either in or out, when their concentration is greater on one side of the membrane than on the other

  D. Enzymes - proteins which act as chemical catalysts in living organisms

  E. Filtration - movement of particles in solution from a place of higher hydrostatic pressure to a place of lower hydrostatic pressure

  F. Histocyte - a tissue cell

  G. Histology - the study of tissue

  H. Homeostasis - a state of chemical balance between a cell and its environment

  I. Hydrostatic pressure - pressure exerted by a liquid within a closed system

  J. Metabolism - sum total of chemical reactions which occur in a living organism

  K. Osmosis - movement of solvent molecules through a semipermeable membrane from region of higher water concentration to lower concentration

  L. Physiology - study of the functions of the body parts and how they function to form a complete living organism

  M. Protoplasm - living substance of all cells

    a. Composition - 70% water, calcium, phosphorus, etc.

    b. Characteristics - irritability, motility, metabolism, growth, and reproduction

  N. Biology - the study of all forms of life

  O. Angiology - study of the circulatory system

  P. Arthrology - study of joints

Q. Dermatology - study of skin, hair, and nails

R. Endocrinology - study of the endocrine (hormonal) system

S. Myology - study of the muscular system

T. Neurology - study of the nervous system

U. Osteology - study of the skeletal system

V. Splanchnology - study of the digestive, reproductive, urinary, and respiratory systems

II. Cells (HO 1) **(II-2)**

A. Description

1. Microscopic in size

2. The basic unit of structure and function of all living things

3. Come in a variety of sizes and shapes

B. Structure

1. Cell membrane

a. The cell membrane surrounds each cell.

b. It separates the cell's cytoplasm from its external environment and from the neighboring cells.

c. It is a "selective semi-permeable membrane"; it allows certain substances to move through it but prevents other substances from passing through it.

d. The membrane is made up of lipid (fatty substance) and protein.

2. Cytoplasm

a. The cytoplasm is a sticky semi-fluid material found between the nucleus and the cell membrane.

b. Organelles are located in the cytoplasm. They are cell structures which help the cell to function. Organelles consist of the nucleus, mitochondria, ribosomes, golgi apparatus, endoplasmic reticulum, and lysosomes.

3. Nucleus

    a. Most important organelle

    b. Located in or near the center of the cell

    c. Controls the activities of cells and cell division (reproduction)

    d. The nucleus of each species contains a specific number of chromosomes. Human beings have 46 chromosomes (23 pairs). Chromosomes store hereditary material that is passed on from one generation to the next.

4. The nuclear membrane

    a. The nuclear membrane is a double layered membrane that has openings at regular intervals.

    b. Material can pass from the nucleus to the cytoplasm or from the cytoplasm to the nucleus through these openings.

5. Mitochondria

    a. An organelle the provides all of a cell's energy

    b. Vary in shape and size; can be a single or as many as a thousand in each cell

C. Function **(II-3)**

1. Metabolism - process by which cells build protein and produce energy

2. Respiration - exchange of gases (CO_2 and O_2)

3. Nutrition - nourishment

4. Excretion - eliminating of waste products

5. Reproduction (mitosis) - reproduce self; increase total amount of protoplasm

6. Irritability - responds to a change in environment

7. Conductivity - transmission of nerve impulses

8. Contractility - the ability to contract or shorten

III. Tissues

A. Epithelial **(II-4)**

1. Simple squamous
    a. Lines alveoli of lungs and blood and lymphatic vessels
    b. Function - absorption, filtration, and osmosis
2. Stratified squamous
    a. Surface of the skin (epidermis) and surface of the lining of the mouth and esophagus
    b. Function - protection
3. Simple columnar
    a. Surface layer of lining in the intestines, stomach, and part of the respiratory tract
    b. Function - secretion, absorption and protection

B. Connective

1. Areolar
    a. Located between organs and other tissue
    b. Function - connects
2. Adipose (fat)
    a. Serves as padding for various parts of the body and located under the skin
    b. Function - protects, insulation, support, reserve of food
3. Dense fibrous
    a. Tendons, ligaments, and scars
    b. Function - connective
4. Bone
    a. Skeleton
    b. Function - protect and support
5. Cartilage

        a. External ear, part of the nasal septum, disks between vertebrae, articular surface of bones, rings of trachea, larynx

        b. Function - flexible support

    C. Muscle

      1. Skeletal

        a. Muscles that attach to bones, eye ball muscle, upper third of esophagus

        b. Function - movement of bones, eye movement, first part of swallowing

      2. Cardiac

        a. Wall of heart

        b. Function - contraction of heart

      3. Visceral

        a. In the wall of the digestive, respiratory, and genitourinary tracts; walls of blood and lymphatic vessels, ducts of glands, eye muscles, arrector muscles of hair

        b. Function - movement of substance along tracts, change in diameter of blood vessels, pupils and shape of the lens of the eye, erection of hairs (goose bumps)

    D. Nerve

      1. Brain, spinal cord, nerves

      2. Receives stimuli and conducts impulses to and from all body parts

IV. Membranes - thin, soft sheets of tissue that line a tube or cavity, that cover organs or structures, or that separate one part from another **(II-5)**

    A. Mucous

      1. Lines body cavities that open to outside **(II-6)**

      2. Secretes mucus

    B. Serous

      1. Lines body cavities that do not open to the exterior

      2. Secretes serous fluid

3. Prevents friction

C. Cutaneous - covers body, skin

D. Synovial

1. Acts as a cushion

2. Lines joint cavities

3. Secretes synovial fluid

V. Organs **(II-7, 8)**

A. A group of similar tissues performing the same function

B. Examples - heart, lung, stomach, etc.

VI. Systems **(II-9)**

A. A group of organs performing the same function

B. Example - circulatory, digestive, urinary, endocrine, reproductive systems, etc.

VII. Summary and Conclusion

A. Terms and definitions

B. Cells

C. Tissues

D. Membranes

E. Organs

F. Systems

It is amazing how each cell can function independently or in concert with other cells to form body systems which provide for our existence. The next unit will be on the skin and its appendages.

LESSON PLAN: 18

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

INTERACTION ITEMS:

1. What is the definition of anatomy, physiology, biology, arthrology, neurology, osmosis, filtration, protoplasm, enzymes, homeostasis, diffusion, metabolism, and cytology?
2. Where on Handout 1 are the following located: cell membrane, cytoplasm, nucleus, and mitochondrion?
3. What are the functions of a cell?
4. What are the four types of body tissues?
5. What are four types of body membranes?
6. What are the functions of mucous, serous, cutaneous, and synovial membranes?
7. What is an organ?
8. How many examples of an organ can you name?
9. What is a body system?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Examine prepared microscope slides of various types of tissues.
2. Divide class into small groups and discuss why knowledge of body organization is important to:
    a. Laboratory technician
    b. Physician
    c. Physical therapist
    d. Nurse
    e. Other health occupations
3. Explain and show the different organs of the anatomical model.

4. Have students look up the function of ribosomes, golgi apparatus, endoplasmic reticulum, and lysosomes.

ANSWERS TO EVALUATION ITEMS:

1. e
2. f
3. b
4. a
5. c
6. a
7. b
8. c
9. d
10. e
11. f
12. g
13. h
14. (Any five of the following:)
    a. Metabolism
    b. Respiration
    c. Nutrition
    d. Excretion
    e. Reproduction
    f. Conductivity
    g. Contractibility
    h. Irritability
15. a. Cell membrane
    b. Cytoplasm
    c. Nucleus
    d. Mitochondria
16. a. Muscle
    b. Nerve
    c. Connective
    d. Epithelial
17. c
18. d
19. a
20. b
21. c
22. Can be any of the following:
    heart
    lungs
    liver
    kidneys
    gall bladder
    pancreas, etc.
23. b

LESSON PLAN: 18

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT V : CONCEPTS OF THE BODY AS A WHOLE

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I

____ 1. Neurology

____ 2. Anatomy

____ 3. Biology

____ 4. Physiology

____ 5. Arthrology

Column II

a. Study of the functions of body parts and how they function to form a complete living organism

b. The study of all forms of life

c. Study of joints

d. Study of skeletal system

e. Study of nervous system

f. Study of the shape and structure of the body

Match terms associated with the organization of the body in Column I to their correct definitions in Column II.

Column I

____ 6. Osmosis
____ 7. Filtration
____ 8. Protoplasm
____ 9. Enzymes
____ 10. Homeostasis
____ 11. Diffusion
____ 12. Metabolism
____ 13. Cytology

Column II

a. Living substance of all cells

b. Proteins which act as chemical catalysts in living organisms

c. Study of cells, their origin, structure, and functions

d. Movement of particles through cell membrane, either in or out, when their concentration is greater on one side of the membrane than on the other

e. Movement of particles in solution from a place of higher hydrostatic pressure to a place of lower hydrostatic pressure.

f. A state of chemical balance between a cell and its environment

g. Sum total of chemical reactions which occur in a living organism

h. Movement of solvent molecules through a semipermeable membrane from a region of higher water concentration to lower concentration

14. List five functions of cells.

a.

b.

c.

d.

e.

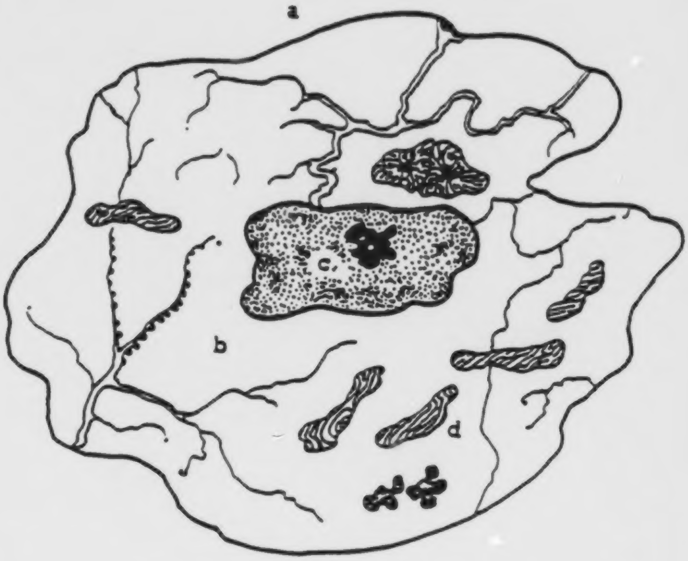
15. Label the parts of the cell indicated on the diagram.

a.

b.

c.

d.



16. The four basic types of tissues in the body are:

a.

b.

c.

d.

Match the following membranes with their functions.

	Membrane		Function
____ 17.	Mucous	a.	Covers body skin
____ 18.	Serous	b.	Acts as cushion, lines joints, secretes synovial fluid
____ 19.	Cutaneous	c.	Lines body cavities that opens to the outside and secretes mucus
____ 20.	Synovial		
		d.	Lines body cavities that do not open to the outside and secrete serous fluid

21. An organ is: (Circle the letter of the best answer.)

- a. The basic unit of structure.
- b. Tissue which lines a cavity.
- c. A group of tissue performing a same function.
- d. The same as a system.

22. List three examples of an organ.

a.

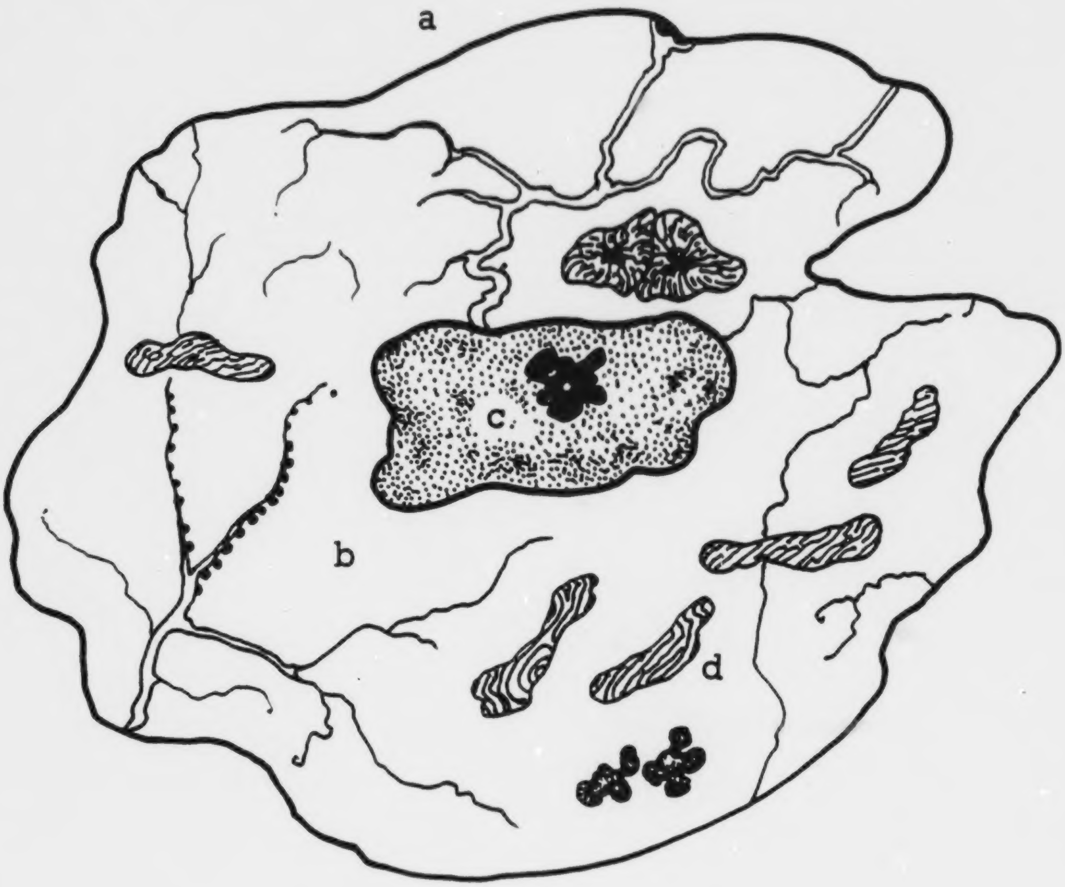
b.

c.

23. A system is: (Circle the letter of the best answer.)

- a. Tissue which lines a cavity to the outside.
- b. A group of organs performing the same function.
- c. A group of tissues performing the same function.
- d. The same as an organ.

THE CELL



a. Cell membrane

b. Cytoplasm

c. Nucleus

d. Mitochondrion

LESSON PLAN: 19

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-19 OR DEMONSTRATION:

SKIN SYSTEM

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with the correct definition.
2. Name the two main layers of the skin.
3. Label the various structures of the skin.
4. List five functions of the skin.
5. Match the appendages of the skin with their functions.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Skin Section
2. Anatomy charts

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 19 (Student Reference page 321) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, New York: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

The skin is classified as an organ and a system. The skin, due to the large area it covers, is the largest organ in the body and one of the most important. If approximately one third of the skin of a healthy adult is destroyed, death usually occurs. Melanin, a pigment found in the outer layer of the skin, gives us our skin color. The amount of melanin in your skin depends on the genes you inherited from your parents. The more melanin, the deeper the skin color.

LESSON PLAN: 19

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Terms and Definitions

   A. Dermal - of or pertaining to the skin **(II-1)**

   B. Dermatitis - inflammation of the skin

   C. Dermatologist - specialist in the diagnosis and treatment of skin diseases

   D. Dermatosis - any generalized skin disease

   E. Dermatomycosis - any fungal disease of the skin

   F. Sarcoma - tumor of fleshy or connective tissue

II. Structure of the Skin (HO 1) **(II-2, 3)**

   A. Two main layers

      1. Epidermis - outer, thinner layer; consists of stratified squamous epithelial tissue

      2. Dermis - lower layer; inner, thicker layer

         a. Consists of fibrous connective tissue

         b. Subcutaneous fat - part of the dermis

         c. Blood vessels - pass through elastic fibers in the dermis

         d. Hair follicle and shaft - consist of a root and shaft. Root is implanted in the skin. The shaft is the part that projects from skin surface.

         e. Sweat glands and ducts - The glands are located in the subcutaneous tissue just under the dermis. Small dusts connect the sweat glands to pinpoint-sized openings on the skin (pores).

         f. Nerve endings - located under the epidermis and around hair follicles

III. Functions of the Skin

A. Protection **(II-4)**

1. Protects against daily invasion of deadly microbes

2. Bars entry of harmful chemicals

3. Prevents suns ultraviolet rays from penetrating into interior of the body

B. Environmental adjuster - sense organ receptors reveal changes in environment which could be harmful if not detected

C. Manufactures vitamin D - must have sunshine

D. Regulates body temperature and fluid content by varying the amount of sweat secreted

1. To lose heat (cool) **(II-5)**

a. Blood vessels dilate, bringing heat to skin.

b. Skin temperature rises, so more heat is lost to cooler environment.

c. Sweat is released to cool by evaporation.

2. To conserve heat (warm)

a. Sweating stops.

b. Blood vessels constrict.

c. Skin temperature falls.

E. Excretion of wastes

IV. Appendages of the Skin

A. Glands

1. Sudoriferous - produce sweat **(II-6)**

2. Sebaceous - secretes sebum, a fatty material which lubricates the skin to keep it soft and pliable

3. Ceruminous - produce ear wax

B. Hair - protection; covers entire body except palms of hands and soles of feet **(II-7)**

C. Nails - protection to nerve endings in fingers and toes; contain keratin, a protein substance that makes nails stiff

V. Summary and Conclusion

A. Terms and Definitions

B. Structure of the skin

C. Function of the skin

D. Appendages of the skin

Good care of the skin and its appendages is as important to your appearance and well-being as it is to those you care for in the health care facility. The next lesson is on personal care for the client.

LESSON PLAN: 19

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What are the definitions of terms found in this lesson?

2. What are the two main layers of the skin?

3. Where are the following structures located on HO 1: hair shaft, nerve endings, epidermis, dermis, blood vessel, sweat gland, fat, hair follicle.

4. What are the five functions of the skin?

5. How does the skin regulate body temperature?

6. What are the functions of the sudoriferous, sebaceous, and ceruminous glands, hair and nails?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Cosmetologist or dermatologist to speak about skin and hair care.

2. Examine a specimen of skin, hair, and nails under the microscope and compare the structure with a model or drawing of the skin.

3. Have students follow the lecture with HO 1 to visually identify the structures of the skin.

ANSWERS TO EVALUATION ITEMS:

1. e
2. f
3. b
4. a
5. d
6. Dermis and epidermis
7. Hair shaft
8. Nerve ending
9. Epidermis
10. Dermis
11. Blood vessel
12. Sweat gland
13. Fat

14. Hair follicle

15. a. Protection
    b. Environmental adjuster
    c. Manufactures vitamin D
    d. Regulate body temperature
    e. Excretion

16. a. To lose heat (cool)
        1. Blood vessels dilate, bringing heat to skin
        2. Skin temperature rises, so more heat is lost to cooler environment
        3. Sweat is released to cool by evaporation
    b. To conserve heat (warm)
        1. Sweating stops
        2. Blood vessels constrict
        3. Skin temperature falls

17. b
18. c
19. e
20. d
21. a

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LESSON PLAN: 19

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

Match the definition in Column II with the correct term in Column I.

Column I	Column II
____ 1. Dermal	a. Inflammation of the skin
____ 2. Dermatomycosis	b. Tumor of fleshy or connective tissue
____ 3. Sarcoma	c. Any generalized skin disease
____ 4. Dermatitis	d. Specialist in the diagnosis and treatment of skin disease
____ 5. Dermatologist	e. Of or pertaining to the skin
	f. Any fungal disease of the skin

6. The two main layers of the skin are the ____________ and ____________.

Label the structures of the skin marked on the diagram.

7. ______________________

8. ______________________

9. ______________________

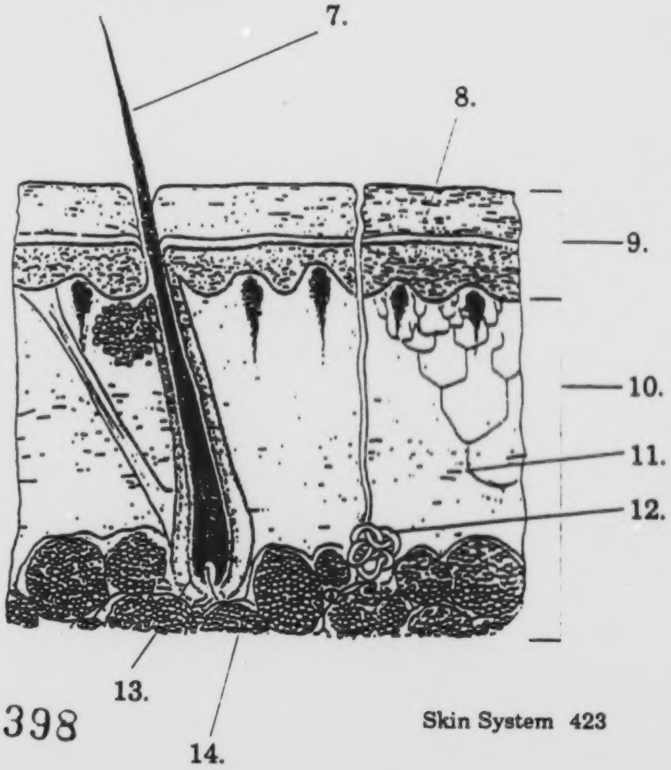
10. ______________________

11. ______________________

12. ______________________

13. ______________________

14. ______________________



15. The five functions of the skin are:

  a.

  b.

  c.

  d.

  e.

16. Explain how the skin regulates body temperature.

  a. To lose heat

    1.

    2.

    3.

  b. To conserve heat

    1.

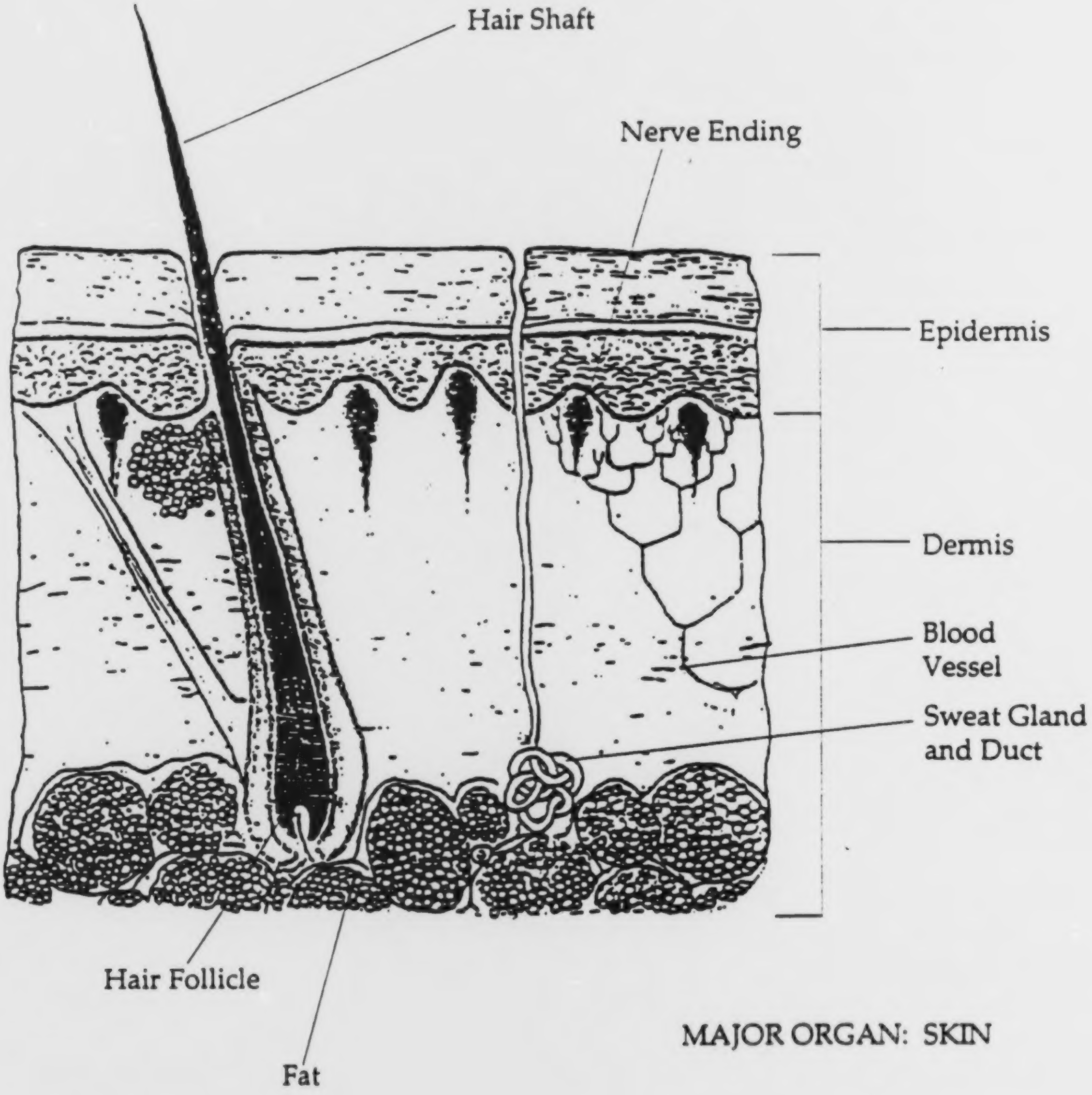
    2.

    3.

Match the terms related to skin appendages in Column II with the definitions in Column I.

		Column I		Column II
____	17.	Protects the body but is not found on the palms of hands and soles of feet.	a.	Ceruminous glands
____	18.	Protects nerve endings in toes.	b.	Hair
____	19.	Produces sweat.	c.	Nails
____	20.	Secretes sebum, a fatty substance.	d.	Sebaceous glands
____	21.	Produces wax.	e.	Sudoriferous glands

SKIN SECTION


Hair Shaft
Nerve Ending
Epidermis
Dermis
Blood Vessel
Sweat Gland and Duct
Hair Follicle
Fat

MAJOR ORGAN: SKIN

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LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-20 AND DEMONSTRATION: VI-20

PERSONAL CARE FOR THE CLIENT
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson with their correct definitions.
2. Identify activities that make up personal care.
3. Identify points to consider when planning personal care.
4. Identify clients who need assistance with general hygiene.
5. Identify appropriate clothing for client.
6. Identify key points involved in providing personal care.
7. Identify points to remember when performing personal care activities.
8. Identify adaptive measures that may be necessary to take when giving personal care to clients with special conditions.

Demonstration

9. Shave client with safety razor according to the steps of procedure.
10. Shave client with electric razor according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Television and VCR
2. HO 1: Shaving the Client
3. Razor (safety and electric)
4. Mirror
5. Shaving cream
6. Washcloth
7. After-shave lotion and preshave lotion (electric)
8. Gloves
9. Audiovisuals available from the Missouri Vocational Resource Center
    a. Techniques in Toileting and Personal Care, video #15, 19 min.
    b. Techniques in Personal Care, video #7, 22 min.
10. The Eye From the Inside Out, video (TF #75), available from the Missouri Division of Aging Film Library, 21 min.

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 20 (Student Reference page 329) prior to class and be prepared to discuss the information presented and return the demonstrations on shaving.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 23.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6, Section 4.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 21.

INTRODUCTION:

This lesson applies to individuals in long-term care facilities and residential care facilities. Although some procedures are the same for individuals in acute care facilities. Personal care is important to everyone. Think about what we do to improve our looks. The client in the health care facility requires the same care; and you, as a health care assistant, must either see that the client does these things, assist them, or complete them for the client. In order to maintain the dignity of the individual, the client must be helped to look as good as possible.

LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Terms and Definitions **(II-1)**

  A. Aspiration - to draw food or other objects into lungs

  B. Gangrene - death of tissue usually due to deficient or absent blood supply

  C. Activities of daily living - activities we do each day such as brushing our teeth, washing our face, taking a bath, dressing, etc.

  D. Dentures - artificial teeth which replace all or part of a person's teeth

  E. Hygiene - clean and sanitary

  F. Self care - activities which the client performs

  G. Oral - pertains to the mouth

  H. Oral hygiene - cleaning the mouth and teeth

  I. Antiperspirant - a skin care product that reduces the amount of perspiration

II. Personal Care or Activities of Daily Living (ADL) **(II-2)**

  A. These are activities we learn as children and perfect to suit our needs as adults.

  B. Activities include

    1. Bathing

    2. Oral hygiene

    3. Hair care

    4. Nail care

    5. Dressing

    6. Shaving

III. Planning of Personal Care **(II-3)**

A. Know what your assigned clients are capable of doing.

B. Don't try to save time by doing activities of daily living that the client is capable of doing. This can result in dependency.

C. The client should have as much control as possible over when and how personal care will be carried out.

D. If you do the personal care for the client, allow him/her to have input.

Examples: How do you want your hair arranged? What outfit do you want to wear today?

E. Remember, you are invading the client's personal space.

F. Treat the client with respect while assisting him/her.

G. The adult client is not a child and cannot be treated as a child.

H. Assist the client only as needed.

IV. General Hygiene **(II-4)**

A. Helps to maintain a positive self-image

B. Supports good health

C. Eye sight of the elderly often becomes less sharp. Hands may tremble. Activities take effort and energy.

1. Clothes may be soiled
2. Hair unkempt
3. Teeth not brushed
4. Food spilled on clothing
5. Shirts not properly buttoned

D. Clients needing help with general hygiene

1. Client who is weak because of illness
2. Those who have body changes due to illness which affect their ability to do personal hygiene
3. Excessive perspiration

    4. Vomiting

    5. Incontinent of urine or feces

    6. Drainage from any body opening or wound

    7. Any client on bed rest

V. Selection of Clothing **(II-5)**

  A. Clothing represents individuality and identity.

  B. Our own clothes enhance our self-image.

  C. Choose clothing appropriate for the type of activity that the client will be participating in that day and the weather.

  D. Wear lightweight warm clothing in layers for warmth.

  E. Long robes can cause tripping.

  F. Select client's color preference. Match colors appropriately. Bright colors can lift the spirits.

  G. Shoes and stockings should fit.

  H. Round garters and stockings that roll and twist can cause poor circulation. Garter belts and pantyhose are best for the elderly.

  I. Underclothes should provide support but should be the individual's choice of the client. Example: Some men prefer boxer shorts and others prefer tight-fitting shorts.

  J. Label clothes on the inside of the garment with owner's name.

VI. Activities of Personal Care - Key Points **(II-6)**

  A. Cleanliness: Bathing

    1. Types of baths

      a. Bed

      b. Tub

      c. Shower

    2. Taking a tub or shower bath once or twice a week may be sufficient because the skin in elderly people becomes thinner and dryer. Some people prefer daily baths. Acute care clients are bathed daily.

3. Partial baths can be given more frequently (face, mouth care, hands, axillary, and perineal area).

4. Apply lotion to back and feet.

5. Give nail care and wash hands after toileting, before meals, and as needed.

B. Bed making

1. Types

a. Unoccupied

b. Occupied

2. Should be neatly made up.

3. Change linens as needed.

C. Oral hygiene - mouth care

1. Give A.M. and after meals

2. Inspect client's mouth and report anything unusual.

3. Safely store dentures when out of the mouth.

D. Shaving

1. Usually needed once or twice a week.

2. Let clients shave themselves if they are able to. Shaving is a good exercise.

3. Electric razors are safest. Do not share client's razor with others.

4. Many females also shave.

5. Ask females if they would like you to shave their legs and underarms.

6. Perform shaving procedure in the client's bedroom or bathroom, not in a public area.

7. Always apply lather or shaving cream before shaving with a safety razor. This helps to soften the beard and prevents skin irritation.

8. For a comfortable and easy shave, remember to shave in the direction that hair grows; downward over the cheeks and chin; upward over the neck area.

9. With gloved hand, apply pressure to nicked skin using a clean cloth for a minute or so until oozing stops. Notify nurse.

10. Electrical cords should not come into contact with water.

11. Dispose of safety razor in sharps container.

E. Skin care

1. Inspect skin for bruises, rashes, scratches, and broken and red areas - report immediately if observed.

2. Apply lotion to dry skin.

3. Give back rub.

F. Hair care

1. Hair care reminds the client and the health care assistant of the client's worth as a human being. It also helps stimulate the client's scalp.

2. Brush gently from scalp to ends.

3. For tangles, separate them from the rest of the hair, hold hair gently near the scalp, and brush or comb out tangle from end to scalp.

4. Observe for sores, dandruff, lice, and nits.

5. Let client care for own hair if possible.

6. Shampooing should be done once a week or more often if necessary.

G. Nail care

1. Dirt that has collected under nails is a source of infection.

2. Clean nails daily.

3. Keep nails short to prevent scratches.

4. Soak nails in warm water for a few minutes before cutting them.

5. NEVER cut a diabetic's toenails.

6. Trim nails straight across.

H. Dressing and undressing

1. Clients in long-term care need day clothes and night clothes. This will help remind even the confused client about time.

2. Alterations in clothing may be necessary due to the client's condition. Remember, you must have the permission of the client or family to alter clothing.

I. Hearing aid

1. Many elderly clients wear hearing aids.

2. Hearing aids should always be handled carefully and should not be allowed to get wet. When the aid is not in use, it should be in the off position. Before giving a hearing aid to the client to place in his/her ear, check that the batteries are functioning. If needed, assist the client in adjusting the volume of the hearing aid.

J. Eye glasses

1. Handle eye glasses only by the frames.

2. Clean eye glasses daily and when needed with cleaning solution or water.

3. Glasses should be dried with a clean, soft tissue.

4. When glasses are not in use, they should be placed in an eye glass case.

VII. Points to Remember When Performing Personal Care Activities **(II-7)**

A. Wash your hands before and after a procedure.

B. Assemble all equipment needed before starting a procedure.

C. Use only the client's own personal care items. Never borrow from another client.

D. Greet the client by name and identify yourself.

E. Give a thorough explanation of what you are going to do.

F. Respect privacy of client.

1. Close doors.

2. Pull curtains.

3. Cover client with bath blanket.

G. Allow the client to perform any part of the procedure he/she is able to do; inability to perform personal care means a loss of independence for the client.

H. Use good body mechanics.

1. Bend at the knees.

2. Use arm and leg muscles.

I. Remember safety factors. **(II-8)**

1. Prevent falls; use nonskid mat in tub or shower.

2. Prevent burns; always check temperature of water with the inside of your forearm or wrist before using on the client.

3. Lock shower chairs and wheelchairs when not using to push client.

4. Bathroom doors must remain unlocked.

5. In acute care, the health care assistant must remain with client at all times.

J. Provide warmth. **(II-9)**

1. Bath blanket prevents chilling before and after bath.

2. Elderly are more prone to chilling due to poor circulation.

3. Keep door shut to shower room to conserve heat and avoid drafts.

K. Make observations during personal care activities.

1. See

2. Smell

3. Hear

4. Touch

VIII. Adaptive Measures for Special Conditions

A. The unconscious client **(II-10)**

1. Client cannot respond but still needs to be given an explanation. He/she may be able to hear although he/she cannot respond.

2. Get assistance to move the client.

3. To prevent choking or aspiration of fluid into the lungs, turn client to side. **(II-11)**

4. Leave client positioned in proper body alignment.

5. Check frequently for incontinence.

B. The paralyzed client

1. Handle affected side with care; support joints.
2. Do not leave client lying on affected side very long--may cause swelling.
3. Maintain proper positioning for good circulation.
4. Dress affected side first.
5. Never use the terms "bad side" or "good side" when giving care.

C. The diabetic client

1. Good skin care is necessary. Observe the skin for breakdown or tears and report to the charge nurse.
2. Feet and legs are susceptible to poor circulation. Shoes may also cause reduced circulation.
3. NEVER trim the toenails of a diabetic client. If skin is nicked, it may become infected which can lead to gangrene and eventual amputation.
4. A diabetic's wounds heal more slowly due to poor circulation. **(II-12)**

IX. Demonstrate Procedures for Shaving. **(II-13, 14, 15, 16, 17, 18)**

X. Summary and Conclusion

A. Terms and definitions

B. Description of personal care or activities of daily living

C. Planning of personal care

D. General hygiene

E. Selection of clothing

F. Activities of personal care

G. Points to remember when performing personal care activities

H. Adaptive measures necessary for special conditions

I. Review procedures for shaving.

You will spend most of your hours at work carrying out these personal care activities. Remember you are with the client more than anyone else on the health care team. You are the eyes, ears, and nose for him/her--make pertinent observations and meet the client's emotional needs during this time, too. Do not concentrate only on the physical aspects of the care. The next lesson is on a bed bath.

LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR SHAVING CLIENT WITH SAFETY RAZOR:

1. Assemble necessary equipment.

2. Wash your hands. Put on gloves.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Position client in chair or sitting position in bed in well-lit area.

7. Spread towel under client's chin.

8. Wet face with warm water.

   NOTE: Warm water softens the beard and makes shaving smoother.

9. Apply shaving cream 1/8" thick to face.

10. Leave lather in place about 15-30 seconds.

11. Start stroking downward with razor under sideburns and work downward over the cheek.

12. Continue over the chin. Work upward on neck under the chin. Use short, firm strokes.

13. Rinse the razor often in water.

14. Shave area around lips carefully.

    NOTE: You may need to stretch skin gently to shave in creases and sensitive areas.

15. When finished shaving, wash the face of any excess soap or lather.

16. Pat face dry with a towel.

17. Apply after-shave lotion if the client requests it or if it is part of his usual routine.

18. Place call signal within reach, if needed.

19. Remove, clean, and store equipment.

20. Remove and dispose of gloves according to facility policy. Wash hands.

21. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR SHAVING CLIENT WITH ELECTRIC RAZOR:

1. Assemble necessary equipment.

2. Wash your hands. Put on gloves.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Sanitize razor head.

7. Position client in chair or sitting position in bed in well-lit area.

8. Spread towel under client's chin.

9. Wash face thoroughly with soap and water to remove dirt and oil.

10. Apply preshave lotion if client requests it or if it is part of his usual routine.

11. Start shaving from sideburns holding skin tight and using circular motions; shave neck and around mouth.

12. When finished, apply after-shave lotion if client requests it or if it is part of his usual routine.

13. Sanitize razor head.

14. Place call signal within reach, if needed.

15. Remove, clean, and store equipment.

16. Remove and dispose of gloves according to facility policy. Wash hands.

17. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What are the definitions of terms used in this lesson?
2. What personal care activities do you perform every day for yourself when you get up in the morning?
3. How do you plan the personal care of a client?
4. How can you identify a client who needs assistance with general hygiene?
5. What should you remember when selecting clothing for a client?
6. What activities make up personal care?
7. When would you borrow one client's personal care equipment for use on another client?
8. How are falls prevented in the shower or tub?
9. How do you provide warmth to the elderly during a bath? During a shower?
10. Why is it important to give explanations to the unconscious client?
11. Why should the unconscious client never be given oral fluids?
12. Why do diabetic clients' wounds heal slower?
13. How thickly do you apply the shaving cream or lather?
14. How long should the lather be left on before shaving?
15. What type of stroking motion do you use when shaving with a safety razor?
16. What can you do to make it easier to shave around the mouth area?
17. What is the first step when shaving with an electric razor?
18. What type of motion is used when shaving with an electric razor?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisuals.
2. Have a class discussion of personal care activities that students perform each morning.
3. Discuss the importance of privacy when performing personal care.
4. Instructor should demonstrate shaving a client.
5. Students should practice shaving a client.

ANSWERS TO EVALUATION ITEMS:

1. c
2. b
3. f
4. a
5. e
6. c
7. d
8. a
9. b
10. once or twice
11. c
12. c
13. infection
14. wet
15. frames
16. b
17. circulation
18. incontinence
19. affected
20. diabetic

LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

		Column I		Column II
____	1.	Oral hygiene	a.	Death of tissue usually due to deficient or absent blood supply
____	2.	Activities of daily living	b.	Activities we do each day
____	3.	Aspiration	c.	Cleaning the mouth and teeth
____	4.	Gangrene	d.	Artificial teeth
____	5.	Hygiene	e.	Clean and sanitary
			f.	To draw food or other objects into the lungs

6. Personal care includes all of the following except: (Circle the letter of the best answer.)

   a. Shaving
   b. Hair care
   c. Cleaning the client's room
   d. Oral hygiene

7. When planning personal care, the health care assistant should: (Circle the letter of the best answer.)

   a. Save time by doing activities which the client is capable of doing.
   b. Tell the client you must give personal care now because you are busy.
   c. Choose clothing for the client because you have better taste than he/she does.
   d. Know what your assigned client is capable of doing.

8. Clients who need assistance with general hygiene are: (Circle the letter of the best answer.)

   a. Those who have body changes due to illness.
   b. Those who are continent of urine and feces.
   c. Those who have no family or friends come to visit.
   d. Those who get dressed and are up in the hall each day.

9. When selecting clothing for the client the health care assistant should: (Circle the letter of the best answer.)

   a. Select stockings that roll at the top.
   b. Select lightweight warm clothing to layer for warmth.
   c. Select the first clothing you see in the closet.
   d. Select long robes that cover the ankles.

10. Due to the elderly skin being thinner and dryer, a tub or shower bath is usually given ______________ or ______________ a week.

11. The client's hands are washed and nail care given if needed: (Circle the letter of the best answer.)

    a. After applying lotion to the hands.
    b. Before visitors arrive.
    c. After toileting and before meals.
    d. One or two times a week.

12. Which of the following statements are true regarding shaving a client? (Circle the letter of the best answer.)

    a. Straight razors are the safest.
    b. Shaving may be performed when the client is in the lounge.
    c. Do not share electric razors with other clients.
    d. Shave in the opposite direction the hair grows.

13. Dirt that collects under the fingernails is a source of ________________.

14. Hearing aids should not be allowed to get ________________.

15. Eye glasses are handled only by the ____________________.

16. When performing personal care activities, the health care assistant should: (Circle the letter of the best answer.)

    a. Remember to lock the bathroom door.
    b. Wash their hands before and after procedures.
    c. Borrow personal care items from the other client in the room.
    d. Have the client check the temperature of the bath water before getting in.

17. The elderly are more prone to chilling due to poor __________________.

18. The unconscious client should be checked frequently for ________________.

19. The health care assistant should dress the paralyzed client's __________________ side first.

20. A __________________ wound heals more slowly due to poor circulation.

LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT:_______________

SHAVE CLIENT WITH SAFETY RAZOR

EQUIPMENT:

1. Basin/sink of hot water
2. Safety razor
3. Mirror
4. Shaving cream
5. Washcloth
6. After-shave lotion
7. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Assemble necessary equipment.		
2. Wash your hands. Put on gloves.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Position client in chair or sitting position in bed in well-lit area.		
7. Spread towel under client's chin.		
8. Wet face with warm water. NOTE: Warm water softens the beard and makes shaving smoother.		
9. Apply shaving cream 1/8" thick to face.		
10. Leave lather in place about 15-30 seconds.		
11. Start stroking downward with razor under sideburns and work downward over the cheek.		
12. Continue over the chin. Work upward on neck under the chin. Use short, firm strokes.		
13. Rinse the razor often in water.		

14.	Shave area around lips carefully. NOTE: You may need to stretch skin gently to shave in creases and sensitive areas.		
15.	When finished shaving, wash the face of any excess soap or lather.		
16.	Pat face dry with a towel.		
17.	Apply after-shave lotion if the client requests it or if it is part of his usual routine.		
18.	Place call signal within reach, if needed.		
19.	Remove, clean, and store equipment.		
20.	Remove and dispose of gloves according to facility policy. Wash hands.		
21.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "SHAVE CLIENT WITH SAFETY RAZOR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 20

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT:________________

SHAVE CLIENT WITH ELECTRIC RAZOR

EQUIPMENT:

1. Basin/sink of hot water
2. Electric razor
3. Mirror
4. Face soap
5. Washcloth
6. Preshave lotion
7. After-shave lotion
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Assemble necessary equipment.		
2. Wash your hands. Put on gloves.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Sanitize razor head.		
7. Position client in chair or sitting position in bed in well-lit area.		
8. Spread towel under client's chin.		
9. Wash face thoroughly with soap and water to remove dirt and oil.		
10. Apply preshave lotion if client requests it or if it is part of his usual routine.		
11. Start shaving from sideburns holding skin tight and using circular motions; shave neck and around mouth.		
12. When finished, apply after-shave lotion if client requests it or if it is part of his usual routine.		
13. Sanitize razor head.		

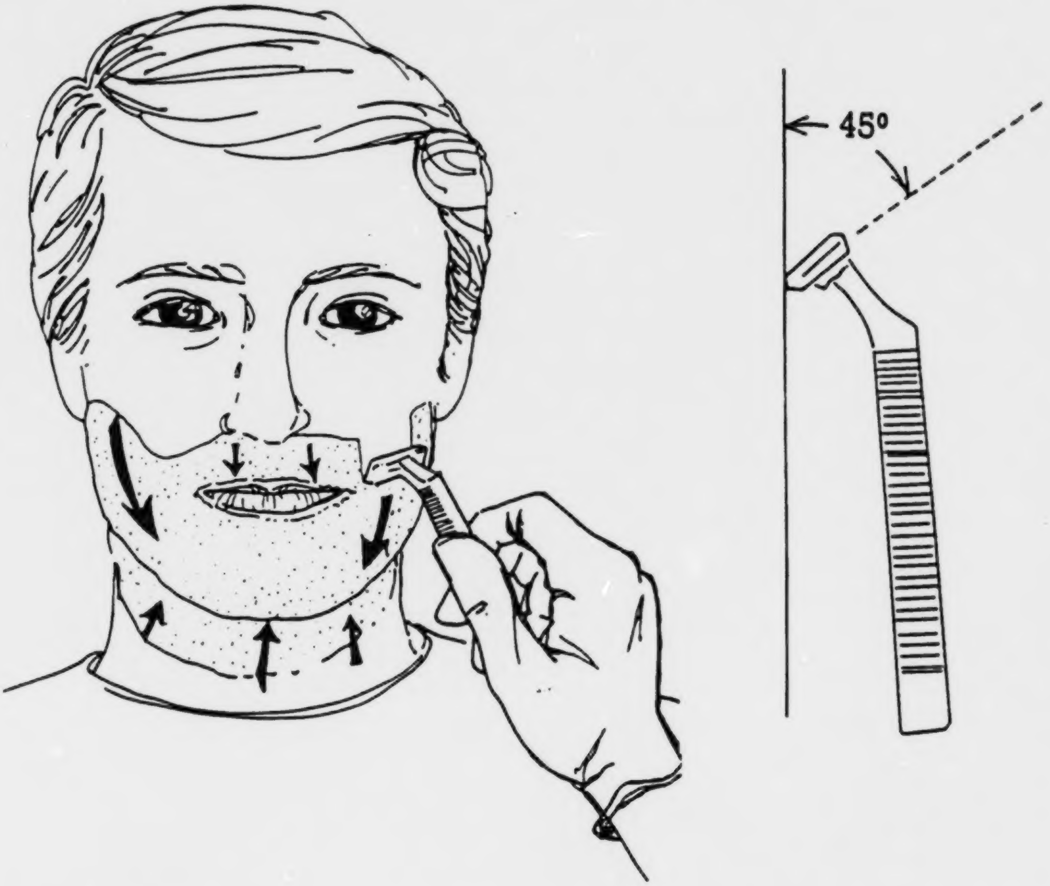
14.	Place call signal within reach, if needed.		
15.	Remove, clean, and store equipment.		
16.	Remove and dispose of gloves according to facility policy. Wash hands.		
17.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "SHAVE CLIENT WITH ELECTRIC RAZOR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

SHAVING THE CLIENT



- Wear gloves.
- Razor should be held at 45° angle to client's skin.
- Shave in the same direction that the hair grows.

LESSON PLAN: 21

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-21 AND DEMONSTRATION: VI-21

BED BATH
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Define terms presented in this lesson.
2. List four purposes of bathing.
3. Describe the difference between a complete bed bath and a partial bed bath.
4. Identify five specific measures related to giving a bed bath.
5. Describe safety measures when bathing a client.

Demonstration

6. Give complete bed bath according to steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Techniques in Bathing, video #16, available from the Missouri Vocational Resource Center, 37 min.
2. Television and VCR
3. Bath basin
4. Soap and soap dish

5. Gloves
6. Bath towels
7. Face towel
8. Deodorant
9. Washcloths
10. Bath blanket
11. Lotion
12. Powder (optional)
13. Linen bag
14. Clean bed linen
15. Gown or pajamas
16. Equipment for oral hygiene, shaving, hair care, and nail care
17. Client's toiletries, cosmetics

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 21 (Student Reference page 347) and be prepared to discuss the information presented and return the demonstration of giving a bed bath according to procedure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 6.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 20.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 21.

INTRODUCTION:

A bed bath is given to any client unable to get out of bed for whatever reason. During the bed bath, other personal care procedures are also performed, including changing the bed linens. The bed bath gives the health care assistant a great opportunity for head-to-toe observation as well as ample time to communicate with the client. It is also a good time to identify any concerns or needs of the client that may be unnoticed during the usual hustle and bustle of the day. The health care assistant should be aware that the client may feel frustrated and embarrassed with having to depend on someone else for a very personal activity. Treat the client with dignity and respect.

LESSON PLAN: 21

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Terms and Definitions

- A. IV - refers to intravenous fluids (II-1)
- B. Infusion site - where the IV needle is inserted
- C. Anus - the outlet of the rectum
- D. Axilla - the arm pit
- E. Genital area - the area which includes the external sex organs and the anus
- F. Perineal area - same as genital area
- G. Deodorant - controls and masks body odor
- H. Pubic - the area of the external genitalia covered with hair

II. Purposes of Bathing (II-2)

- A. Promote cleanliness and comfort
  1. Any time he/she is incontinent, provide peri care as needed.
  2. In acute care facilities, bathe the client daily.
  3. In long-term care facilities, bathe the client at least twice a week if the client is continent and without odor problems.
- B. Stimulate circulation
- C. Relax the client
- D. Observe the condition of the client's body

III. Complete Bed Bath verses Partial Bed Bath

- A. A complete bed bath involves washing the entire body. (II-3)
- B. A partial bed bath involves washing the:

1. Face

2. Hands

3. Underarms

4. Genital area

IV. Specific Measures Related to Giving a Bed Bath

A. Offer the bedpan/urinal before starting the bath procedure because warm water can stimulate the urge to urinate or defecate. (II-4)

B. A washcloth mitten can be used. Avoid dangling the ends of the washcloth, which allow water to drip onto the client.

C. Change water when it becomes soapy, cold, or dirty. Clean, fresh water is necessary to clean the client. (II-5)

D. Do not leave soap in water. Use a soap dish or washcloth to prevent the bath water from becoming too soapy. (II-6)

E. Rinse all soap from skin to prevent drying of the skin.

F. Washing the farthest extremity first prevents dripping water across the part you have already cleaned. (II-7)

G. Place the hands and feet in a basin of water (if client is able). This is relaxing, makes the client feel cleaner, and helps to soften the nails. Nail care may be done at this time. (II-8)

V. Safety Measures to Follow When Bathing A Client (II-9)

A. The room should be warm and free of drafts to prevent chilling.

B. Cover the client with a bath blanket during the procedure to prevent exposing them and to prevent chilling.

C. The temperature of bath water should be approximately 105°F to 115°F. Always use a bath thermometer to check the temperature to make certain the water is not too hot.

D. If the client has an IV, is receiving oxygen, or has drainage tubes:

1. Do not pull or put any stress on the tubes.

2. Make certain the IV container is higher than the infusion site.

3. Never raise drainage tubes above the drainage site.

VI. Demonstrate the Procedure for Giving a Complete Bed Bath. **(II-7, 8)**

VII. Summary and Conclusion

- A. Terms and definitions
- B. Purposes of bathing
- C. Complete bed bath versus partial bed bath
- D. Specific measures related to bathing
- E. Safety measures to follow when bathing a client
- F. Review the procedure for giving a complete bed bath.

The next lesson is on the tub bath and shower bath.

LESSON PLAN: 21

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR A COMPLETE BED BATH:

1. Wash your hands. Put on gloves.
2. Arrange necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Assist with oral hygiene and shaving (if applicable).
7. Offer bedpan/urinal; then empty, clean, and put it away.
8. Remove gloves and dispose in appropriate container. Wash hands. Put on clean gloves.
9. Place client in supine position near the side of the bed nearest you, if assistance is tolerated.
10. Untuck bed linens.
11. Remove bedspread and blanket; fold and place on chair if reusing, otherwise place in linen bag.
12. Cover top sheet with bath blanket. Ask client to hold bath blanket in place; if unable, tuck under client's shoulders.
13. Remove top sheet without disturbing bath blanket and place in linen bag at bedside.
14. Remove client's gown or pajamas.
15. Fill bath basin 2/3 full of warm water (115°F).
16. Place face towel across client's chest.
17. Wet washcloth and squeeze out excess water.
18. Wash eyes first. Start at inner corner and work out. Use different area of washcloth for each eye. Don't dangle the ends of washcloth.

19. Wash, rinse, and dry face, ears, nose, and mouth.

20. Wash, rinse, and dry neck.

21. Expose arm farthest from you; place bath towel under arm up to axilla.

22. If client is able, place basin of water on bed and immerse client's hand in water and wash.

23. Wash and rinse shoulder, axilla, and arm of extremity farthest away.

24. Remove basin and dry arm and shoulder.

25. Repeat steps 21-24 with arm closest to you.

26. May do fingernail care at this point.

27. Place towel across chest and fold bath blanket to waist.

28. Wash and rinse chest and breasts while lifting towel.

29. Dry skin thoroughly.

30. Fold bath blanket to pubic area--keep chest covered with towel.

31. Wash, rinse, and dry abdomen. Remove towel and cover with bath blanket.

32. Change bath water in basin.

33. Expose the farthest leg; flex (bend) leg and place bath towel lengthwise under the leg up to the buttocks.

34. Wash and rinse leg and foot.

35. Dry leg, foot, and in between toes.

36. Repeat steps 33-35 on leg nearest you; cover client with bath blanket.

37. May do toenail care at this point.

38. Place towel and washcloth in linen bag and get clean ones.

39. Change bath water in basin.

40. Ask or assist client to turn on side with back facing you.

41. Fold bath blanket over client's side to expose back and buttocks; place clean towel parallel to client's back.

42. Wash, rinse, and dry back and buttocks.

43. Remove gloves and dispose in appropriate container. Wash hands.
44. Give backrub using warmed lotion paying special attention to bony areas.
45. Put on gloves.
46. Turn client to back; place clean towel under buttocks.
47. If client is able, provide washcloth, soap, and towel and instruct him/her to wash and dry peri area.
48. If client is unable, wash peri area from front to back.
49. Place dirty linen in appropriate container.
50. Remove gloves and dispose in appropriate container. Wash hands.
51. If client did own peri care, provide fresh water for client to wash hands.
52. Apply warmed lotion as needed and deodorant.
53. Put clean clothing on client without exposing him/her.
54. Comb hair, apply cosmetics if applicable.
55. Remove, clean, and store equipment.
56. Wash your hands.
57. Make the client comfortable; place call signal within reach.
58. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 21

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What is the definition of anus, antiperspirant, pubic, deodorant, IV?

2. What are the four purposes of a bed bath?

3. What is the difference between a complete bed bath and a partial bed bath?

4. When is the bedpan or urinal offered during the bath procedure?

5. When is bath water changed?

6. What can be used if no soap dish is available?

7. Why do you wash the farthest extremity first?

8. How full do you fill a bath basin?

9. What part of the body is washed first?

10. What safety measures must the health care assistant take when bathing a client?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisuals.

2. Instructor should demonstrate bed bath procedure.

3. Students should practice bed bath procedure.

ANSWERS TO EVALUATION ITEMS:

1. e
2. c
3. f
4. b
5. a
6. c
7. entire body
8. face
   hands

underarms
genital area
9. c
10. b
11. dry
12. basin water
13. chilling
14. d

LESSON PLAN: 21

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

Match the terms or abbreviations in Column I with their correct definitions in Column II.

	Column I		Column II
____ 1.	Anus	a.	Refers to intravenous fluids
____ 2.	Axilla	b.	Controls and masks body odor
____ 3.	Pubic	c.	The arm pit
____ 4.	Deodorant	d.	Reduces the amount of perspiration
____ 5.	IV	e.	The outlet of the rectum
		f.	The area of the external genitalia covered with hair

6. Which one of the following is not a purpose of bathing the client? (Circle the letter of the best answer.)

   a. Promotes cleanliness and comfort
   b. Stimulates circulation
   c. Promotes dryness of the skin
   d. Relaxes the client

7. A complete bed bath involves washing the (two words) ____________ ____________.

8. List the four areas which a partial bed bath involves washing.

   a.

   b.

   c.

   d.

9. The bedpan should be offered before starting the bath procedure because: (Circle the letter of the best answer.)

   a. It is aggravating to stop in the middle of the procedure to offer the bedpan.
   b. The bath water will get cold while the client uses the bedpan.
   c. Warm water can stimulate the urge to urinate.
   d. There is usually no bedpan in the room during the bath procedure.

10. During a bed bath, the bath water is changed: (Circle the letter of the best answer.)

    a. Every time you wash from the far side to the near side.
    b. When the water becomes soapy, cold, or dirty.
    c. After you wash the face and before washing the far arm.
    d. Before washing the neck and chest.

11. You should rinse all soap from the client's skin to prevent the skin from becoming ____________________.

12. The client's hands and feet should be placed in a ____________________ of ____________________.

13. The client's room, during the bath procedure, should be warm and free of drafts to prevent ____________________.

14. Which one of the following is a correct safety measure to follow when bathing a client? (Circle the letter of the best answer.)

    a. If the client falls, run for help.
    b. The temperature of the bath water should be 120°F.
    c. Make certain IV containers are lower than the infusion site.
    d. Never raise drainage tubes above the drainage site.

LESSON PLAN: 21

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT:________________

GIVE COMPLETE BED BATH

EQUIPMENT:

1. Bath basin
2. Soap and soap dish
3. Bath towels (2)
4. Face towel
5. Washcloths (2)
6. Bath blanket
7. Lotion
8. Deodorant
9. Powder (optional)
10. Linen bag
11. Clean bed linen
12. Gown or pajamas
13. Equipment for oral hygiene
14. Equipment for shaving
15. Equipment for hair care
16. Equipment for nail care
17. Client's toiletries, makeup
18. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Arrange necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Assist with oral hygiene and shaving (if applicable).		
7. Offer bedpan/urinal, then empty, clean, and put it away.		
8. Remove gloves and dispose in appropriate container. Wash hands. Put on clean gloves.		
9. Place client in supine position near the side of the bed nearest you if assistance is tolerated.		
10. Untuck bed linens.		
11. Remove bedspread and blanket; fold and place on chair if reusing, otherwise place in linen bag.		
12. Cover top sheet with bath blanket. Ask client to hold bath blanket in place; if unable, tuck under client's shoulders.		
13. Remove top sheet without disturbing bath blanket and place in linen bag at bedside.		

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
14. Remove client's gown or pajamas.		
15. Fill bath basin 2/3 full of warm water (115° F).		
16. Place face towel across client's chest.		
17. Wet washcloth and squeeze out excess water.		
18. Wash eyes first. Start at inner corner and work out. Use different area of washcloth for each eye. Don't dangle the ends of washcloth.		
19. Wash, rinse, and dry face, ears, nose, and mouth.		
20. Wash, rinse, and dry neck.		
21. Expose arm farthest from you; place bath towel under arm up to axilla.		
22. If client is able, place basin of water on bed and immerse client's hand in water and wash.		
23. Wash and rinse shoulder, axilla, and arm of extremity farthest away.		
24. Remove basin and dry arm and shoulder.		
25. Repeat steps 21-24 with arm closest to you.		
26. May do fingernail care at this point.		
27. Place towel across chest and fold bath blanket to waist.		
28. Wash and rinse chest and breasts while lifting towel.		
29. Dry skin thoroughly.		
30. Fold bath blanket to pubic area--keep chest covered with towel.		
31. Wash, rinse, and dry abdomen. Remove towel and cover with bath blanket.		
32. Change bath water in basin.		
33. Expose the farthest leg; flex (bend) leg and place bath towel lengthwise under the leg up to the buttocks.		
34. Wash and rinse leg and foot.		
35. Dry leg, foot, and between toes.		
36. Repeat steps 33-35 on leg nearest you. Cover client with bath blanket.		
37. May do toenail care at this point.		
38. Place towel and washcloth in linen bag and get clean ones.		

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
39. Change bath water in basin.		
40. Ask or assist client to turn on side with back facing you.		
41. Fold bath blanket over client's side to expose back and buttocks; place clean towel parallel to client's back.		
42. Wash, rinse, and dry back and buttocks.		
43. Remove gloves and dispose in appropriate container. Wash hands.		
44. Give backrub using warmed lotion, paying special attention to bony areas.		
45. Put on gloves.		
46. Turn client to back; place clean towel under buttocks.		
47. If client is able, provide washcloth, soap, and towel and instruct him/her to wash and dry peri area.		
48. If client is unable, wash peri area from front to back.		
49. Place dirty linen in appropriate container.		
50. Remove gloves and dispose in appropriate container. Wash hands.		
51. If client did own peri care, provide fresh water for client to wash hands.		
52. Apply warmed lotion as needed and deodorant.		
53. Put clean clothing on client without exposing him/her.		
54. Comb hair, apply cosmetics if applicable.		
55. Remove, clean, and store equipment.		
56. Wash your hands.		
57. Make the client comfortable; place call signal within reach.		
58. Record observations, reporting anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE COMPLETE BED BATH" according to the steps outlined.

______________________________________ ________________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-22 AND DEMONSTRATION: VI-22

TUB BATH AND SHOWER BATH
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Identify three safety measures to follow while giving a tub bath.
2. Identify three safety measures to follow while giving a shower bath.
3. Identify observations to be made during a tub bath or shower.

Demonstration

4. Give tub bath according to the steps of procedure.
5. Give shower bath according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Shower Chair
2. Bath towels
3. Washcloths
4. Bath blanket
5. Soap and soap dish
6. Bath thermometer, if available

7. Tub/shower chair and chair by side of tub
8. Disinfectant solution and cleaning cloth
9. Nonskid bathtub mat (use a towel if not available)
10. Bath floor mat
11. Clean clothes
12. Personal care items: lotion or powder, shower cap (optional)
13. Gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 22 (Student Reference page 357) and be prepared to discuss the information presented and return the demonstrations on giving a tub bath and shower bath according to procedures.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 6.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 20.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 21.

INTRODUCTION:

A tub bath or shower bath may be given depending on the client's mobility and personal preference. Encourage the client to assist with the bathing if he/she is able. This can promote feelings of independence. If the type of bath assigned to the client does not seem appropriate, consult with the charge nurse and identify the reasons why another type of bath may be better for the client.

Again, this is a prime time for the health care assistant to make observations about the total needs (physical, emotional, and social) of the client. The bath should be a pleasurable experience. Keep in mind the importance of maintaining the client's dignity and respecting his/her privacy.

LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Key Points of Tub Bath

   A. Reasons for giving a tub bath

      1. The tub bath is for clients who can get out of bed but may not like showers.

      2. The tub bath can provide greater relaxation than a bed bath or a shower and give a feeling of being cleaner.

   B. Dangers in giving a tub bath are falls and burns.

   C. Safety measures

      1. The tub should be filled with an adequate amount of warm water (105°F) to cleanse the client; however, keep in mind the client's safety. **(II-1)**

      2. The client usually stays in the tub for 10-15 minutes; longer would allow the water to cool, resulting in the client becoming cold. **(II-2)**

      3. Do not add bath oil to the water. This makes the surface of the tub slippery. **(II-3)**

      4. When a client is agile (able to move without difficulty; nimble), he/she may be left alone in the bathtub--check several times. The door should never be locked.

         NOTE: If you have any doubts about the client's safety in the tub, stay with him/her. Never leave a client in acute care alone in the tub.

      5. If the client becomes faint while having a tub bath: **(II-4)**

         a. Call for help.

         b. Drain the water out of the tub.

         c. Lower the head as much as possible.

         d. Cover the client with a bath blanket.

NOTE: Fainting is caused by the warm water dilating the blood vessels of the skin, increasing the amount of blood in the skin area and decreasing the blood flow to the brain, resulting in the client feeling faint.

6. Always clean the tub before use.

7. Place a bath mat on the bottom of the tub to prevent falls or use non skid tapes.

8. Always drain the tub before the client gets out of the tub. Keep him/her covered to prevent chilling.

9. If you are giving a whirlpool bath, follow the basic tub bath procedure and your facility's specific policies regarding whirlpool equipment safety.

10. Always stay with the client during the procedure.

11. Do not lock the bathroom door.

12. Know where the signal light is in case of an emergency.

13. Assist with transfer activity.

II. Key Points of Shower Bath

A. Reasons for giving a shower

1. The shower is the bath of choice for many of the clients because of poor mobility and difficulty in getting in and out of the bathtub.

2. Showers with long extension hoses are very good for stimulating circulation.

B. Safety measures

1. Adequately cover the client when transporting him/her to and from the shower room to avoid changes in body temperature and unnecessary exposure.

2. Hang the hand-held shower nozzle on the handrail or hook. Do not allow it to rest on the floor.

NOTE: The floor is always considered dirty.

3. Check shower chair wheels prior to using for sticking or wobbling, as well as for a locking mechanism that works.

4. The client in a shower chair should be placed facing the door of the shower stall while the health care assistant gives the shower; this assures better control of the client should he/she become faint. (II-5)

5. The shower should have a temperature regulator and pressure or flow regulator.

6. Never allow a weak or unsteady person to stand in the shower. Have the client use the hand rails for support when getting in and out of the shower.

7. Should the client become faint while having a shower:

   a. Call for help.

   b. Turn off the water.

   c. If the client is standing, have him/her sit down.

   d. Lower his/her head as much as possible.

   e. Cover with a bath blanket.

III. Observations During a Tub Bath or Shower (II-6)

   A. Redness or pale areas over bony areas

   B. Rashes - location and description

   C. Broken skin or bruises

   D. Tender places, dry skin

   E. Drainage

   F. Bleeding

   G. Skin warm or cold to touch

   H. Any complaint of tenderness, discomfort, or pain

   I. The color of the skin and lips

IV. Demonstrate Procedures for Giving a Tub Bath and a Shower Bath.

V. Summary and Conclusion

   A. Key points of tub bath

   B. Key points of shower

C. Observations during a tub bath or shower

D. Review procedures for giving a tub bath and a shower bath.

The next lesson is on hair care.

LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR A TUB BATH:

1. Assemble necessary equipment.
2. See that tub room is free from drafts, preferably 75°-80°F.
3. Check to see if bathtub and bath chair are clean.
4. Place nonskid mat in bathtub.
5. Place floor mat next to bathtub.
6. Place a chair next to tub.
7. Identify and greet client. Identify self.
8. Explain what you are going to do.
9. Wash your hands. Put on gloves.
10. Offer toileting.
11. Provide privacy and assist client to put on robe and slippers.
12. Ambulate or transfer per wheelchair to tub room.
13. Fill tub with 105°F water at least half-full and check water temperature with bath thermometer.
14. Assist client to undress.
15. Assist client into the tub according to facility's procedure.
16. Assist client as needed in washing. If client is unable to help, start with eyes, then wash face, ears, neck, arms, hands, chest, abdomen, and back. (Ask client if he/she wants soap used on face.)
17. Rinse with warm water.
18. Wash legs, feet, and between toes. Rinse well with warm water; discard washcloth in linen container.

19. Ask or assist client to turn slightly to one side. Wash peri area from front to back and discard washcloth in linen container.

20. Wash your hands at tub faucet.

NOTE: A shampoo may be given at this time.

21. Assist client out of the tub; cover with a bath blanket and assist to the chair.

22. Drain tub and remove soap.

23. Remove and discard gloves.

24. Uncover client, one area at a time, and pat dry with a towel.

25. Apply powder, lotion, and deodorant, if applicable.

26. Assist with dressing.

27. Return client to his/her room; assist with any personal care such as shaving, nail care, and hair care.

28. Make client comfortable; place call signal within reach.

29. Return to tub room, remove soiled articles, and clean tub with disinfectant solution.

30. Wash your hands.

31. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR A SHOWER BATH:

1. Assemble necessary equipment.

2. See that shower room is free from drafts, preferably 75°-80°F.

3. Check to see that the shower chair is clean.

4. Place nonskid mat in shower stall if client is standing during shower.

5. Identify and greet client. Identify self.

6. Explain what you are going to do.

7. Wash your hands. Put on gloves.

8. Offer toileting.

9. Provide privacy and assist client to put on robe and slippers.

10. Ambulate or transfer per shower chair to shower room.

11. Assist client to undress; cover him/her with bath blanket until ready to start shower.

12. Adjust spray temperature (95°-105°F). Direct spray away from client while adjusting it. Flow rate should be gentle.

13. Assist client in washing as needed. If client is unable to help at all, start with eyes, then wash face, ears, neck, chest, abdomen, and back. (Ask client if he/she wants soap used on face.)

14. Rinse with warm water.

15. Wash legs, feet, and between toes. Rinse well with warm water; discard washcloth in linen container.

16. Wash peri area from front to back.

    NOTE: Wash female labia area from front of chair; wash anal area from under chair.

17. Wash between buttocks and discard washcloth; rinse well from front to back.

18. Wash hands.

    NOTE: A shampoo may be given at this time.

19. Turn off shower and cover client with bath blanket; place around hair if wet.

20. Assist client out of shower.

21. Remove and dispose of gloves. Wash hands.

22. Uncover client, one area at a time, and pat dry.

23. Apply powder, lotion, and deodorant, if applicable.

24. Assist with dressing.

25. Return client to his/her room; assist with any personal care such as shaving, nail care, and hair care.

26. Make client comfortable; place call signal within reach.

27. Return to tub room, remove soiled articles, and clean tub with disinfectant solution.

28. Wash your hands.

29. Record observations and report anything unusual to charge nurse.

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LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What is the correct water temperature for a tub bath?
2. How long does a client usually stay in the tub?
3. Why is bath oil not added to the water in a bath tub?
4. What should you do first if a client becomes faint while giving a tub bath?
5. How should the shower chair be positioned when you are placing the client in the shower?
6. What kind of observations could you make about the client during a tub bath or shower?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates tub bath procedure.
2. Students assist with tub bath procedure during O.J.T.
3. Instructor demonstrates shower bath procedure.
4. Students assist with shower bath procedure during O.J.T.

ANSWERS TO EVALUATION ITEMS:

1. c
2. b
3. d
4. d
5. c
6. a
7. b
8. b

LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

1. The temperature of the water for a tub bath should be: (Circle the letter of the best answer.)
   - a. 120°F.
   - b. 95°F.
   - c. 105°F.
   - d. 150°F.

2. The client usually stays in the bath tub for: (Circle the letter of the best answer.)
   - a. 25 to 30 minutes.
   - b. 10 to 15 minutes.
   - c. 30 to 35 minutes.
   - d. 35 to 45 minutes.

3. Why shouldn't bath oil be added to the bath water? (Circle the letter of the best answer.)
   - a. Most people do not like the smell.
   - b. The grease on the skin will be difficult to dry.
   - c. It will dry and irritate the skin.
   - d. It will make the surface of the tub slippery.

4. Mrs. Peters is agile and able to take her own bath in the tub. After assisting Mrs. Peters into the tub, you should: (Circle the letter of the best answer.)
   - a. Tell her you will be back in 30 minutes.
   - b. Make certain the bathroom door is locked.
   - c. Tell her to add more hot water if the temperature cools.
   - d. Make certain the bathroom door is not locked.

5. Which one of the following should be placed on the bottom of the bath tub before assisting a client into the tub? (Circle the letter of the best answer.)
   - a. Washcloth and soap
   - b. Washcloth and hand towel
   - c. A bath mat
   - d. A bath blanket

6. If a client becomes weak during the tub bath procedure, the health care assistant should: (Circle the letter of the best answer.)

   a. Call for help and drain the water out of the tub.
   b. Go to the nurses station for help immediately.
   c. Assist the client to stand up.
   d. Remove the client from the tub immediately.

7. Which of the following is not an observation to make during the tub bath or shower? (Circle the letter of the best answer.)

   a. Redness and rashes on the skin
   b. Complaints about taking a bath
   c. Complaints of tenderness, discomfort, or pain
   d. Broken skin and bruises

8. When assisting a client in a shower chair into the shower, the chair should be positioned: (Circle the letter of the best answer.)

   a. Facing the back of the shower stall.
   b. Facing the door of the shower stall.
   c. Facing away from the door of the shower stall.
   d. Facing any way that is convenient for the health care assistant.

LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:_______________

GIVE TUB BATH

EQUIPMENT:

1. Bath towels (2)
2. Washcloths (2)
3. Bath blanket
4. Soap and soap dish
5. Bath thermometer, if available
6. Tub chair and chair by side of tub
7. Disinfectant solution and cleaning cloth
8. Nonskid bathtub mat (use towel if not available)
9. Bath floor mat
10. Clean clothes
11. Personal care items: lotion or powder
12. Shower cap (optional)
13. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. See that tub room is free from drafts, preferably 75°-80°F.		
4. Clean bathtub and tub chair with disinfectant solution and rinse well.		
5. Place nonskid mat, towel, or tub chair in bathtub.		
6. Place floor mat next to bathtub.		
7. Place a chair next to tub.		
8. Identify and greet client. Identify self.		
9. Explain what you are going to do.		
10. Offer toileting.		
11. Provide privacy and assist client to put on robe and slippers.		
12. Ambulate or transfer per wheelchair to tub room.		
13. Fill tub with 105°F water half full and check water temperature with bath thermometer.		

14.	Assist client to undress.		
15.	Assist client into tub.		
16.	Assist client as needed in washing. If client is unable to help, start with eyes, then wash face, ears, neck, arms, hands, chest, abdomen, and back. (Ask client if he/she wants soap used on face.)		
17.	Rinse with warm water.		
18.	Wash legs, feet, and between toes. Rinse well with warm water; discard washcloth in linen container.		
19.	Ask or assist client to turn slightly to one side. Wash peri area from front to back and discard washcloth in linen container.		
20.	Wash your hands at tub faucet. NOTE: A shampoo may be given at this time.		
21.	Assist client out of the tub; cover with a bath blanket and assist to chair.		
22.	Drain tub and remove soap.		
23.	Remove and dispose of gloves.		
24.	Uncover client, one area at a time, and pat dry with a towel.		
25.	Apply powder, lotion, and deodorant, if applicable.		
26.	Assist with dressing.		
27.	Return client to his/her room; assist with any personal care such as shaving, nail care, and hair care.		
28.	Make client comfortable; place call signal within reach.		
29.	Return to tub room, remove soiled articles, and clean tub with disinfectant solution.		
30.	Wash your hands.		
31.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE TUB BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 22

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:________________

GIVE SHOWER BATH

EQUIPMENT:

1. Bath towels (2)
2. Washcloths (2)
3. Bath blanket
4. Soap and soap dish
5. Bath thermometer, if available
6. Shower chair and chair by side of tub
7. Disinfectant solution and cleaning cloth
8. Nonskid bathtub mat (use towel if not available)
9. Bath floor mat
10. Clean clothes
11. Personal care items: lotion or powder
12. Shower cap (optional)
13. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Assemble necessary equipment.		
2. See that shower room is free from drafts, preferably 75°-80°F.		
3. Check to see that the shower chair is clean.		
4. Place nonskid mat in shower stall if client is standing during shower.		
5. Identify and greet client. Identify self.		
6. Explain what you are going to do.		
7. Wash your hands. Put on gloves.		
8. Offer toileting.		
9. Provide privacy and assist client to put on robe and slippers.		
10. Ambulate or transfer per shower chair to shower room.		
11. Assist client to undress; cover him/her with bath blanket until ready to start shower.		
12. Adjust spray temperature (95°-105°F). Direct spray away from client while adjusting it. Flow rate should be gentle.		

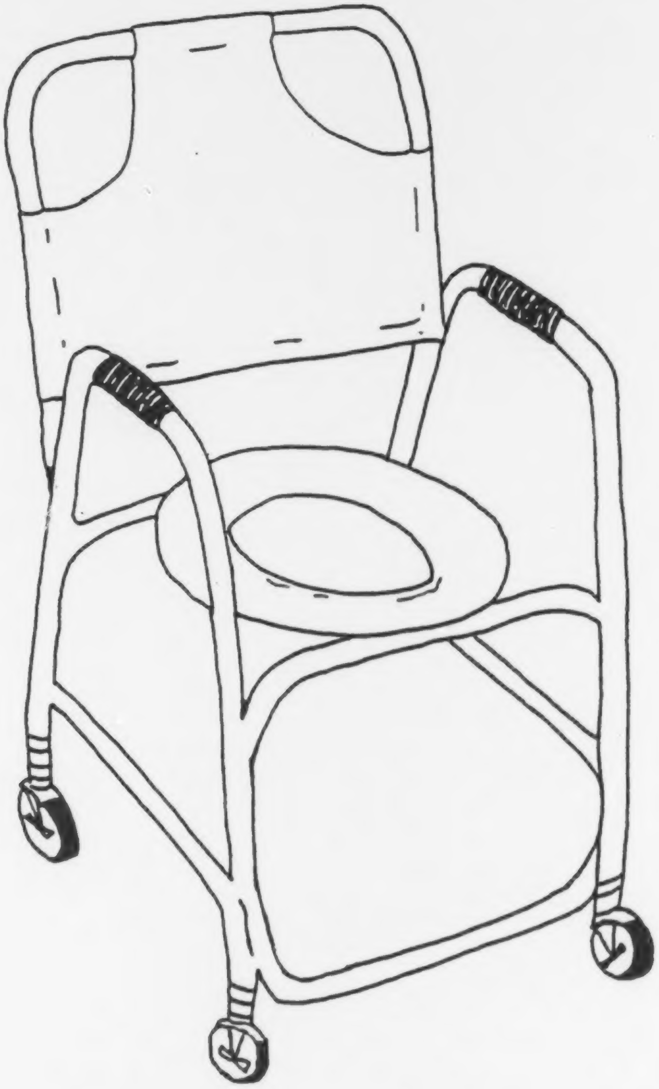
13.	Assist client in washing as needed. If client is unable to help at all, start with eyes, then wash face, ears, neck, chest, abdomen, and back. (Ask client if he/she wants soap used on face.)		
14.	Rinse with warm water.		
15.	Wash legs, feet, and between toes. Rinse well with warm water; discard washcloth in linen container.		
16.	Wash peri area from front to back. NOTE: Wash female labia area from front of chair; wash anal area from under chair.		
17.	Wash between buttocks and discard washcloth; rinse well from front to back.		
18.	Wash hands. NOTE: A shampoo may be given at this time.		
19.	Turn off shower and cover client with bath blanket; place around hair if wet.		
20.	Assist client out of shower.		
21.	Remove and dispose of gloves. Wash hands.		
22.	Uncover client, one area at a time, and pat dry.		
23.	Apply powder, lotion, and deodorant, if applicable.		
24.	Assist with dressing.		
25.	Return client to his/her room; assist with any personal care such as shaving, nail care, and hair care.		
26.	Make client comfortable; place call signal within reach.		
27.	Return to tub room, remove soiled articles, and clean tub with disinfectant solution.		
28.	Wash your hands.		
29.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE SHOWER BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

SHOWER CHAIR



The round opening in the center of the seat makes it easier to give peri care. The wheels should be locked when the chair is in the shower.

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-23 AND DEMONSTRATION: VI-23

HAIR CARE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. List three purposes of hair care.
2. Identify when hair care should be done.
3. Identify two observations to make when giving hair care.
4. Identify specific measures related to hair care.

Demonstration

5. Comb/brush hair according to the steps of procedure.
6. Give shampoo during tub bath/shower bath according to the steps of procedure.
7. Give bed shampoo according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Hair Care for Clients of Color
2. Bath towels
3. Face towel/washcloth
4. Shampoo and hair conditioner/creme rinse (optional)

5. Bath thermometer

6. Pitcher/hand-held shower nozzle

7. Hair dryer for use in client's room

8. Client's personal comb/brush

9. Hand mirror, if available

10. Equipment for bed shampoo:

    a. Shampoo trough/plastic sheet
    b. Large basin/bucket
    c. Bath blanket
    d. Waterproof bed protector
    e. Cotton balls (2)
    f. Small towel
    g. Chair/footstool

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 23 (Student Reference page 369) and be prepared to discuss the information presented and return the demonstrations according to steps of procedures.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 23.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 20, Section 7.

Schniedman, Rose; Susan Lambert. Being a Nursing Assistant. 4th ed. Englewood Cliffs, NJ: The Robert J. Brady Co., 1986. Chapter 12.

INTRODUCTION:

Proper care and styling of the hair are important to the client's appearance and sense of well-being. The client's physical condition and safety concerns, as well as hair and scalp condition and personal preference, may determine frequency and method of shampooing. Shampoos may be given with the tub/shower bath, or a bed shampoo may be necessary. Female clients may want their hair set or rolled before drying. It is the duty of the health care assistant to assist or to care for the client's hair on a daily basis by combing or brushing and arranging it attractively.

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Purposes of Hair Care - Good hair care is important as a morale booster and for maintaining a clean and attractive appearance. **(II-1)**

   A. Clean hair of dirt particles and dead cells; prevent matting

   B. Stimulate circulation of scalp, bringing nutrients to the roots

   C. Improve one's appearance

II. When Hair Care Should be Done **(II-2)**

   A. Combing and brushing should be done in the morning and during the day as needed.

   B. Hair should be washed at least weekly for all clients, and more often if indicated.

   C. Younger clients may have their hair washed daily.

   D. Do not shampoo hair as part of the shower if the client has a regularly scheduled beauty salon appointment.

III. Observations to Make **(II-3)**

   A. Sores

   B. Redness

   C. Dry scalp, excessive dandruff

   D. Swollen areas

IV. Specific Measures Related to Hair Care **(II-4, 5)**

   A. Label client's own comb and brush. Simply write client's name with a permanent marker on a piece of adhesive tape and apply to comb or brush.

   B. When styling hair, place a towel around client's shoulders to prevent hair from getting onto clean clothes or into clothes which causes irritation.

C. Be sure to clean comb and brush after each use.

NOTE: Check policy manual for procedure used in your facility.

D. After washing the hair, rinse all soap from scalp to prevent irritation and dryness. May use a solution of one part white vinegar to five parts water, then follow with warm water rinse.

E. Use hair dryers with extreme caution; check temperature frequently. If using hand-held dryer, keep your hand under air stream so you will know what the temperature is. Do not use near tub since the dryer may come in contact with water and cause electrocution. The hair dryer should be on low setting.

F. Avoid using brush curlers interchangeably between clients. This can be a source of infection.

G. The hair of black people tends to be extremely dry. Hair care includes gently combing hair with a wide-toothed comb and the application of a light oil after washing and combing. (HO 1)

H. When giving a shampoo, the room should be free of drafts, preferable 75° to 80°F to prevent chilling.

I. If using a nozzle to apply water to the hair, keep one finger in stream of water to assure correct temperature of the water.

J. Always obtain permission of the family and client before making a beauty salon appointment.

K. Use of vinegar rinse significantly decreases scalp problems.

V. Demonstrate the Procedures for Giving Hair Care.

VI. Summary and Conclusion

A. Purposes of hair care

B. When hair care should be done

C. Observations to make

D. Specific measures related to hair care

E. Review procedures for giving hair care.

The next lesson is on perineal care.

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR COMBING OR BRUSHING HAIR:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Place the client's towel across pillow if the client is in bed. For the sitting client, place towel around shoulders.
7. If client wears glasses, remove them to a safe place. Remove hairpins, combs, etc.
8. Brush or comb hair gently, using downward strokes.
9. Arrange hair attractively to the client's satisfaction.
10. Let client use the hand mirror.
11. Place call signal within reach.
12. Remove, clean, and store equipment.
13. Wash your hands.
14. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR GIVING SHAMPOO WITH TUB BATH/SHOWER BATH:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

6. Adjust water temperature to 105°-110°F.
7. Position client appropriately in tub or shower.
8. Ask client to hold folded washcloth/face towel over eyes.
9. Apply water to the hair until it is completely wet, using nozzle or pitcher.
10. Apply small amount of shampoo. Work up a good lather, massaging well with fingertips.
11. Rinse thoroughly, working from front to back.
12. Repeat sudsing and rinsing, if necessary.
13. Apply vinegar water, conditioner, or creme rinse as directed. Rinse thoroughly.
14. Towel-dry with second towel, if necessary.
15. Encourage client to comb own hair to remove snarls and tangles, if able.
16. Apply rollers or set hair if this is to be done.
17. Dry hair quickly.
18. When hair is dry, remove curlers. Comb or brush hair and arrange attractively.
19. Let client use the hand mirror; make the client comfortable.
20. Place call signal within reach.
21. Remove, clean, and store equipment.
22. Wash your hands.
23. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR GIVING A BED SHAMPOO:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Raise the bed to its highest horizontal position.

7. Place chair or footstool at the side of the bed near the client's head and cover with a small towel. Set large basin or bucket on chair.

8. Move client to side of bed. Cover with bath blanket and fanfold top linens to foot of bed without exposing the client.

9. Remove pillow and replace with waterproof bed protector.

10. Place one towel under client's head and one around shoulders.

11. Place shampoo trough or arrange plastic sheet under head to form a drain into the bucket.

12. Put a cotton ball in each ear of the client.

13. Apply water to hair until it is completely wet, using pitcher.

14. Apply small amount of shampoo. Work up a good lather, massaging with fingertips.

15. Rinse thoroughly, working from front to back.

16. Repeat sudsing and rinsing, if necessary.

17. Apply vinegar rinse, conditioner, or creme rinse as directed. Rinse thoroughly.

18. Squeeze excess water from hair; apply towel to hair.

19. Remove shampoo trough and place in bucket.

20. Remove cotton balls from client's ears. Using another towel, dry client's hair.

21. Encourage client to comb own hair to remove snarls and tangles, if able.

22. Apply rollers or set hair if this is to be done.

23. Dry hair quickly.

24. When hair is dry, remove curlers. Comb or brush hair and arrange attractively.

25. Let client use the hand mirror; make the client comfortable.

26. Place call signal with reach.

27. Remove, clean, and store equipment.

28. Wash your hands.

29. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What are three purposes of hair care?
2. When should hair care be done?
3. What observations are made while giving hair care?
4. What precautions does the health care assistant take when using a hair dryer?
5. What are five specific measures related to hair care?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates shampoo procedures and combing/brushing the hair.
2. Students arrange each other's hair.
3. Students give shampoo and hair care under the supervision of the OJT supervisor.

ANSWERS TO EVALUATION ITEMS:

1. c
2. b
3. c
4. d
5. b

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

1. Which one of the following is NOT a purpose of routine hair care? (Circle the letter of the best answer.)

   a. Improves the client's appearance
   b. Stimulates circulation of the scalp
   c. Prevents the spread of lice in the facility
   d. Prevents matting and cleans the hair

2. Which one of the following is a true statement concerning hair care? (Circle the letter of the best answer.)

   a. Hair care is only given in the beauty salon.
   b. Hair should be washed weekly and more often if necessary.
   c. Hair should be brushed 100 strokes before going to bed at night.
   d. The elderly clients hair should be washed daily.

3. Which one of the following is NOT an appropriate observation while doing hair care? (Circle the letter of the best answer.)

   a. Sores
   b. Redness of the scalp
   c. Needs to be dyed
   d. Dandruff

4. A precaution to take when using a hair dryer is: (Circle the letter of the best answer.)

   a. Set the control to hot setting.
   b. Dry the hair while the client is in the tub.
   c. When using a hand held dryer, never put your hand under the air stream.
   d. Use extreme caution and check temperature frequently.

5. Which of the following statements is true about giving hair care? (Circle the letter of the best answer.)

   a. Brush curlers may be shared with other clients.
   b. Clean the comb and brush after each use.
   c. Make a beauty salon appointment for the client anytime you think he/she needs one.
   d. Never use vinegar to rinse the hair.

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:____________

COMB/BRUSH HAIR

EQUIPMENT:

1. Client's personal comb/brush
2. Hand mirror, if available

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Place the client's towel across pillow if the client is in bed. For the sitting client, place around shoulders.		
7. If client wears glasses, remove them to a safe place. Remove hairpins, combs, etc.		
8. Brush or comb hair gently using downward strokes.		
9. Arrange hair attractively to the client's satisfaction.		
10. Let client use the hand mirror.		
11. Place call signal within reach.		
12. Remove, clean, and store equipment.		
13. Wash your hands.		
14. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "COMB/BRUSH HAIR" according to the steps outlined.

____
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

____
Date

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT: ______________

GIVE SHAMPOO DURING TUB BATH/SHOWER BATH

EQUIPMENT:

1. Bath towels (2)
2. Face towel/washcloth
3. Shampoo
4. Hair conditioner/creme rinse (optional)
5. Bath thermometer
6. Pitcher/hand-held shower nozzle
7. Hair dryer for use in client's room
8. Client's personal comb/brush
9. Hand mirror, if available

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Adjust water temperature to 105°-110°F.		
7. Position client appropriately in tub or shower.		
8. Ask client to hold folded washcloth/face towel over eyes.		
9. Apply water to the hair until it is completely wet using nozzle or pitcher.		
10. Apply small amount of shampoo. Work up a good lather, massaging with fingertips.		
11. Rinse thoroughly working from front to back.		
12. Repeat sudsing and rinsing, if necessary.		
13. Apply vinegar water, conditioner, or creme rinse as directed. Rinse thoroughly.		
14. Towel-dry with second towel, if necessary.		

15.	Encourage client to comb hair to remove snarls and tangles, if able.		
16.	Apply rollers or set hair if this is to be done.		
17.	Dry hair quickly.		
18.	Remove curlers when hair is dry. Comb or brush hair and arrange attractively.		
19.	Let client use the hand mirror; make the client comfortable.		
20.	Place call signal within reach, if needed.		
21.	Remove, clean, and store equipment.		
22.	Wash your hands.		
23.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE SHAMPOO DURING TUB BATH/SHOWER BATH" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 23

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:______________

GIVE BED SHAMPOO

EQUIPMENT:

1. Bath towels (2)
2. Face towel/washcloth
3. Shampoo
4. Hair conditioner/creme rinse (optional)
5. Bath thermometer
6. Pitcher/hand-held shower nozzle
7. Hair dryer for use in client's room
8. Client's personal comb/brush
9. Hand mirror, if available
10. Shampoo trough/plastic sheet
11. Large basin/bucket
12. Bath blanket
13. Waterproof bed protector
14. Cotton balls (2)
15. Small towel
16. Chair/footstool

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Arrange necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Raise the bed to its highest horizontal position.		
7. Place chair or footstool at the side of the bed near the client's head and cover with a small towel. Set large basin or bucket on chair.		
8. Move client to side of bed. Cover with bath blanket and fanfold top linens to foot of bed without exposing the client.		
9. Remove pillow and replace with waterproof bed protector.		
10. Place one towel under client's head and one around shoulders.		

11.	Place shampoo trough or arrange plastic sheet under head to form a drain into the bucket.		
12.	Put a cotton ball in each ear of the client		
13.	Apply water to hair until it is completely wet, using pitcher.		
14.	Apply small amount of shampoo. Work up a good lather, massaging well with fingertips.		
15.	Rinse thoroughly, working from front to back.		
16.	Repeat sudsing and rinsing, if necessary.		
17.	Apply vinegar rinse, conditioner, or creme rinse as directed. Rinse thoroughly.		
18.	Squeeze excess water from hair; apply towel to hair.		
19.	Remove shampoo trough and place in bucket.		
20.	Remove cotton balls from client's ears. Using another towel, dry client's hair.		
21.	Encourage client to comb own hair to remove snarls and tangles, if able.		
22.	Apply rollers or set hair if this is to be done.		
23.	Dry hair quickly.		
24.	When hair is dry, remove curlers. Comb or brush hair and arrange attractively.		
25.	Let client use the hand mirror; make the client comfortable.		
26.	Place call signal within reach.		
27.	Remove, clean, and store equipment.		
28.	Wash your hands.		
29.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE BED SHAMPOO" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

HAIR CARE FOR CLIENTS OF COLOR

Hair texture can range from incredibly thick and coarse to thin and silky. Clients of color with thick and coarse hair have special hair care needs. The hair/scalp should be oiled lightly each week. It should be given a shampoo every week or two. If the hair is washed too often, it will dry out and possibly break off.

To wash coarse, thick hair, use a good softening shampoo such as Johnson's Baby Shampoo™ or a special professional shampoo. Since the hair tangles easily, use a conditioning detangler, such as Johnson's Baby Conditioner™ or a special professional conditioner. (If the professional shampoos and conditioners are to be used, the client or his/her family should provide them.) The procedure for washing hair is the same as with other types of hair.

After shampooing the hair, gently towel dry. Use a wide-toothed comb to comb through the hair while it is damp. Apply a hair dressing. If the hair is to be braided, it can be braided while it is damp, but it takes about four hours for it to dry naturally. After it is braided, you could use a hair bonnet dryer or blow dryer to dry the hair more quickly. Also, you could let the hair dry hanging loose, but you must constantly comb the hair to prevent bad tangles. Then, apply a hair cream/dressing to the hair and braid.

If the client would like the hair curled, apply a wet-hair setting lotion to each section of hair. Roll each section on a metal or hard plastic roller. Cover the hair with a net. The hair is now ready to be dried. Use a bonnet dryer. This may take 45 minutes. Unroll the hair and style as desired.

Hair can be straightened with a hot/warm pressing iron by a beautician with the permission of the client or his/her family. After the hair is completely heat dried, the beautician applies a hair cream/dressing lightly to each hair section. Then, the beautician presses the hair from the hair root to the hair tip. When the beautician has completed pressing all the hair, a curling iron can be used to curl hair in the style desired. To maintain the hair style, the health care assistant can oil the hair/scalp lightly each week and roll the hair on sponge curlers (wrapped in paper, towel, tissue, etc.) each night.

Courtesy: Mary Moore, RN, Inservice Department, Christian Health Care Center, St. Louis, MO.

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-24 AND DEMONSTRATION: VI-24

PERINEAL CARE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. List two purposes of peri care.
3. Identify when peri care should be given.
4. Identify specific observations to make while giving peri care.
5. Identify specific measures to take while giving peri care.

Demonstration

6. Give perineal care for the male client according to the steps of procedure.
7. Give perineal care for the female client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Perineal Area of the Male and Female
2. Basin of warm water
3. Washcloth (disposable type, if available)
4. Disposable/reusable bed protector

5. Towel
6. Bath blanket
7. Soap and soap dish
8. Powder (optional)
9. Gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 24 (Student Reference page 383) and be prepared to discuss the information presented and return the demonstrations according to procedure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 21.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 30, Section 5.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 40, Section 10.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6.

INTRODUCTION:

Perineal (abbreviated peri) care is a very important procedure. Many clients will be modest about having someone else clean their peri areas. Therefore, you should make an effort to respect the client's modesty and still get the area thoroughly cleaned. A new client may not understand what you are going to do when you say, "I'm going to give you perineal (peri) care. It may be necessary to explain that you are going to wash the area between his/her legs or the private area.

Odor is a reliable indicator of whether or not a client is adequately cleaning this area of his/her body. You may need to offer your assistance. The procedure is basically the same for the male and female client, but it will be presented separately since the organs are different for each sex. If the client has an indwelling catheter, you should give peri care first, then proceed with catheter care.

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Terms and Definitions (II-1)

  A. Anus - outlet of the rectum

  B. Circumcised - surgical removal of the end of the foreskin of the penis

  C. Foreskin - loose skin at and covering the end of the penis

  D. Labia - the skin folds which are on both sides of the urethra and vagina

  E. Urinary meatus - opening of the urethra on the body surface through which urine is discharged

  F. Peri care - cleaning the genital and anal areas; part of bath or shower procedure or a separate procedure (II-2)

  G. Perineal - the genital and anal areas

  H. Scrotum - the pouch containing the testicles

II. Purposes of Peri Care (II-3)

  A. To clean that area for the client who is unable to or has difficulty with adequately cleaning self

  B. Prevent skin breakdown of peri area

  C. Prevent infection and odors

  D. Promote comfort

III. When Client Should Have Peri Care (II-4)

  A. Continent clients - daily

  B. Incontinent clients - after each voiding or stool

  C. When the client has an indwelling catheter - at least once each shift and after every BM

  D. After some surgeries and after childbirth

IV. Observations to Make (II-5)

A. Discharge or odors

B. Signs of skin breakdown--redness, irritation, rashes

V. Specific Measures Related to Peri Care (HO 1)

A. Wash from front to back to prevent spreading fecal matter from anal area to vagina or urethra (opening to bladder). Always be very gentle when washing the area. Remember the rule - work from the cleanest area to the dirtiest. area. **(II-6)**

B. Offer client bedpan/urinal before starting. Warm water on the peri area may stimulate the need to urinate.

C. For uncircumcised males, retract foreskin and cleanse tip of penis, then return foreskin over tip of penis; if not returned, constriction may be caused, which could lead to tissue damage. Leaving foreskin retracted will cause swelling and pain. Gentle handling of the penis may help prevent the penis from becoming erect. If an erection occurs, care may be completed. If the health care assistant wishes, he/she may wait until the penis becomes soft again.**(II-7)**

D. Wear gloves to protect yourself and the client.

E. The perineal area is more sensitive to temperature than the rest of the body. The water may be more comfortable if it is slightly cooler than the temperature of bath water. **(II-8)**

F. Have client in the supine (back-lying) position when giving peri care. **(II-9)**

G. Peri care for the male client is started at the tip of the penis. **(II-10)**

H. If the client is able, he/she should be allowed to perform his/her own peri care to prevent embarrassment.

VI. Demonstrate Procedures for Giving Peri Care

VII. Summary and Conclusion

A. Terms and definitions

B. Purposes of peri care

C. When clients should have peri care

D. Observations to make

E. Specific measures related to peri care

F. Review procedures for giving peri care.

The next lesson is on nail care.

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR GIVING PERI CARE TO THE MALE CLIENT:

1. Wash your hands. Put on gloves.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Client should be in supine or side-lying position; place bed protector under buttocks.
7. Fill basin with warm water.
8. Cover client with bath blanket.
9. Expose perineal area. Using a circular motion, gently wash the penis by lifting it and cleaning from the tip downward. Rinse and dry.

   NOTE: If client is uncircumcised, retract (pull back) the foreskin, wash, rinse, and dry; then pull skin over end of penis.
10. Wash and rinse the scrotum.
11. Wash and rinse other skin areas between the legs.
12. Wash and rinse the anal area.
13. Pat the peri area dry.
14. Apply powder under scrotum to prevent rubbing on skin (optional).
15. Remove disposable bed protector and bath blanket.
16. Place call signal within reach, if needed.
17. Remove, clean, and store equipment.
18. Remove gloves and dispose in appropriate container.
19. Wash hands.

20. Make the client comfortable.
21. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR GIVING PERI CARE TO THE FEMALE CLIENT:

1. Wash your hands. Put on gloves.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Assist client to supine or side-lying position; place bed protector under buttocks.
7. Cover client with bath blanket.
8. Expose peri area. Gently wash the inner legs and outer peri area along the outside of the labia.

   NOTE: Use a clean area of washcloth for each wipe.
9. Wash the outer skin folds from front to back.
10. Wash the inner labia from front to back.
11. Gently open all skin folds and wash the inner area from front to back.
12. Rinse the area well, starting with innermost area and proceeding outward.
13. Wash and rinse the anal area.
14. Pat the peri area dry.
15. Apply powder lightly to outer peri area (optional).
16. Remove disposable bed protector and bath blanket.
17. Place call signal within reach, if needed.
18. Remove, clean, and store equipment.
19. Remove gloves and dispose in appropriate container.
20. Wash your hands.
21. Make the client comfortable.
22. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. **What are the definitions for anus, circumcised, foreskin, labia, perineal, and scrotum?**
2. **What area of the body is cleaned when giving peri care?**
3. **What is the purpose of peri care?**
4. **When should peri care be given?**
5. **What observations should be made when giving peri care to the client?**
6. **How do you cleanse the perineal area when giving peri care?**
7. **What is the procedure for giving peri care to the uncircumcised male?**
8. **What is the temperature of the water used for peri care?**
9. **What position should the client be in during peri care?**
10. **Where do you start peri care for the male client?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates peri care procedure for male client.
2. Students practice peri care procedure for male client.
3. Instructor demonstrates peri care procedure for female client.
4. Students practice peri care procedure for female client.

ANSWERS TO EVALUATION ITEMS:

1. e
2. b
3. c
4. f
5. a
6. d

7. a
8. c
9. d
10. b
11. c
12. d
13. a
14. supine
15. tip, penis

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

Match the following terms in Column I to the correct definitions in Column II.

	Column I		Column II
___ 1.	Perineal	a.	Outlet of rectum
___ 2.	Circumcised	b.	Surgical removal of the end of the foreskin of the penis
___ 3.	Foreskin	c.	Loose skin at and covering the end of the penis
___ 4.	Scrotum	d.	The skin folds which are on both sides of the urethra and vagina
___ 5.	Anus	e.	The area between the pubic bone back to and including the anus
___ 6.	Labia	f.	The pouch containing the testicles

7. You are assigned to care for Max Hill. You tell Mr. Hill that you are going to give him peri care. He asks you, "What is peri care? What are you going to do to me? Your best response to Mr. Hill would be: (Circle the letter of the best answer.)

   a. "It is the cleaning of the private area which consists of the genital and anal area."
   b. "Why do you ask? You know I'm going to take good care of you."
   c. "Peri care is a nursing procedure that is always done because the Doctor order it."
   d. "Don't worry. I'm not going to hurt you."

8. Which of the following is NOT a purpose of peri care? (Circle the letter of the best answer.)

   a. Prevent skin breakdown
   b. Promote comfort
   c. Promote dryness of the skin
   d. Prevent infection and odors

9. A new co-worker asks you which clients are to receive peri care. You would tell the new co-worker: (Circle the letter of the best answer.)

   a. Only the clients you feel need peri care.
   b. Only female clients receive peri care.
   c. The elderly clients receive peri care, the young do not need peri care
   d. Daily for those clients who are continent and after each voiding and stool for clients who are incontinent.

10. Which of the following is NOT an observation that a health care assistant makes when giving peri care: (Circle the letter of the best answer.)

   a. Discharge.
   b. Stool on the rectum.
   c. Signs of skin breakdown.
   d. Odors.

11. When giving peri care, you should clean from: (Circle the letter of the best answer.)

   a. The anal area to the front.
   b. Buttocks to the front.
   c. The urethra to the anal area.
   d. The anal area to the urethra.

12. When giving peri care to an uncircumcised male, you should: (Circle the letter of the best answer.)

   a. Leave the foreskin retracted after peri care.
   b. Give peri care only when the penis is erect.
   c. Not retract the foreskin when cleansing the tip of the penis.
   d. Retract the foreskin, cleanse tip, and return foreskin to its natural position.

13. The temperature of water when giving peri care should be: (Circle the letter of the best answer.)

   a. Cooler than bath water.
   b. Warmer than bath water.
   c. The same temperature as bath water.
   d. A lot hotter than bath water.

14. When giving peri care the client should be in the ____________________ position.

15. Peri care for the male client is started at the ____________________ of the ____________________.

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT:______________

GIVE PERINEAL CARE TO MALE CLIENT

EQUIPMENT:

1. Basin of warm water
2. Washcloth (disposable type, if available)
3. Disposable/reusable bed protector
4. Towel
5. Bath blanket
6. Soap and soap dish
7. Powder (optional)
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Client should be in supine or side-lying position; place bed protector under buttocks.		
7. Fill basin with warm water.		
8. Cover client with bath blanket.		
9. Expose perineal area. Using a circular motion, gently wash the penis by lifting it and cleaning from the tip downward. Rinse and dry.		
10. Wash and rinse the scrotum.		
11. Wash and rinse other skin areas between the legs.		
12. Wash and rinse the anal area.		
13. Pat the peri area dry.		

14. Apply powder under scrotum to prevent rubbing on skin (optional).		
15. Remove disposable bed protector and bath blanket.		
16. Place call signal within reach, if needed.		
17. Remove, clean, and store equipment.		
18. Remove gloves and dispose in appropriate container.		
19. Wash hands.		
20. Make the client comfortable.		
21. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE PERINEAL CARE TO MALE CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 24

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT:______________

GIVE PERINEAL CARE TO FEMALE CLIENT

EQUIPMENT:

1. Basin of warm water
2. Washcloth (disposable type, if available)
3. Disposable/reusable bed protector
4. Towel
5. Bath blanket
6. Soap and soap dish
7. Powder (optional)
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Assist client to supine or side-lying position; place bed protector under buttocks.		
7. Cover client with bath blanket.		
8. Expose peri area. Gently wash the inner legs and outer peri area along the outside of the labia. NOTE: Use a clean area of washcloth for each wipe.		
9. Wash the outer skin folds from front to back.		
10. Wash the inner labia from front to back.		
11. Gently open all skin folds and wash the inner area from front to back.		
12. Rinse the area well, starting with innermost area and proceeding outward.		

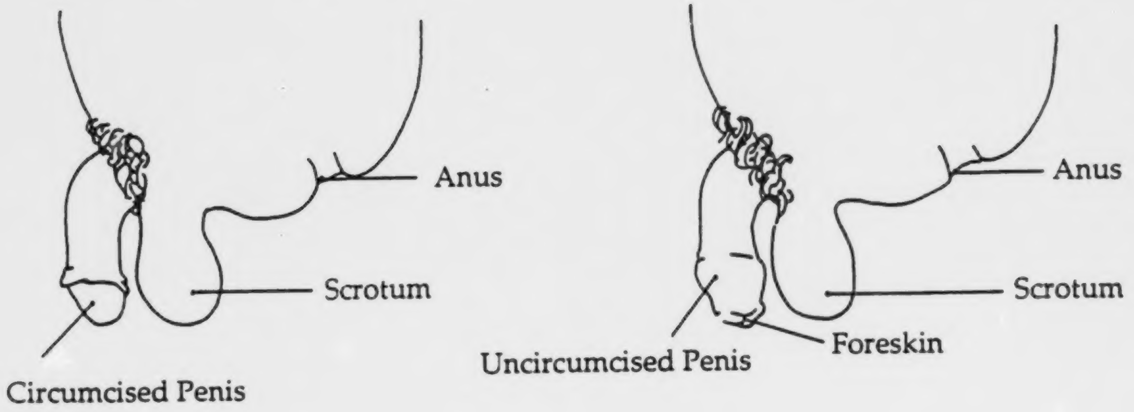
13. Wash and rinse the anal area.		
14. Pat the peri area dry.		
15. Apply powder lightly to outer peri area (optional).		
16. Remove disposable bed protector and bath blanket.		
17. Place call signal within reach, if needed.		
18. Remove, clean, and store equipment.		
19. Remove gloves and dispose in appropriate container.		
20. Wash your hands.		
21. Make the client comfortable.		
22. Record observations and report anything unusual to charge nurse.		

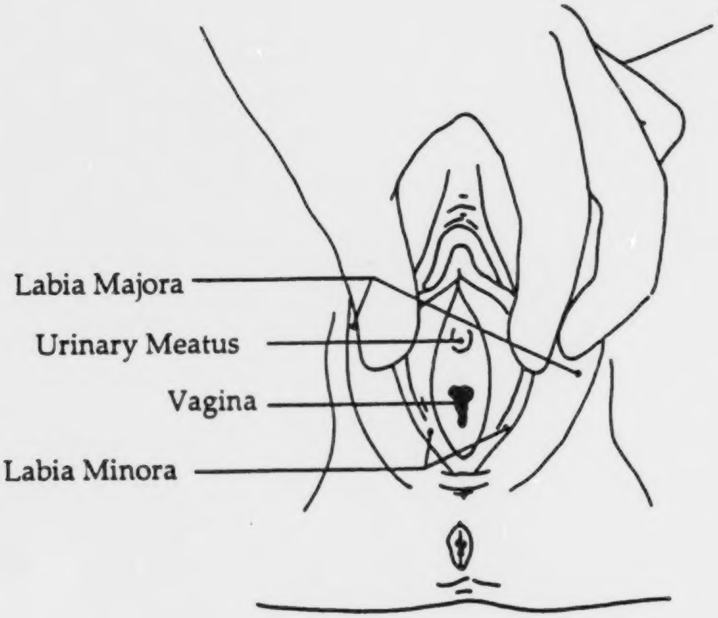
The student has satisfactorily completed the procedure "GIVE PERINEAL CARE TO FEMALE CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

PERINEAL AREA OF THE MALE AND FEMALE


Anus
Scrotum
Circumcised Penis
Anus
Scrotum
Foreskin
Uncircumcised Penis


Labia Majora
Urinary Meatus
Vagina
Labia Minora

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-25 AND DEMONSTRATION: VI-25

NAIL CARE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Define cuticle, ingrown nails, and podiatrist.
2. List two purposes of nail care.
3. Identify observations to make when giving nail care.
4. Identify three specific measures related to nail care.

Demonstration

5. Give fingernail care according to the steps of procedure.
6. Give toenail care according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Wash basin - 3/4 full of warm, soapy water
2. Pitcher of warm water
3. Towel and paper towel
4. Disposable/reusable bed protector
5. Orange stick/flat toothpick

6. Emery board/nail file
7. Nail clippers
8. Lotion

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 25 (Student Reference page 395) and be prepared to discuss the information presented and return the demonstration of giving fingernail and toenail care according to procedures.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 23.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6, section 4.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 20, Section 7.

Sorrentino, Sheila. Textbook for Nursing Assistant, 3rd ed. St. Louis, MO: Mosby Year Book Inc., 1992. Chapter 13.

INTRODUCTION:

Nail care is an important aspect of the personal care of the client. It includes cleaning and trimming the fingernails and toenails on a regular basis. The part of the nail we see is not living tissue; but the skin around and under the nail is living tissue and needs to be protected from injury and infection. Toenails tend to be thicker than fingernails, particularly as a person ages. Always check with the charge nurse or check the care plan to learn if toenail care in the facility can be given by a nursing assistant, if it is permitted for your assigned client, or if it is to be modified in any way.

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Terminology **(II-1, 2, 3)**

A. Ingrown nails - nails that grow in at the side

B. Cuticle - base of the fingernail

C. Podiatrist - a physician specialized in the care of the feet

II. Purposes of Nail Care **(II-4)**

A. Decrease bacteria build-up under nail which could cause infections

B. Give the client a neat appearance

C. Prevent cuts/scratches from long nails

NOTE: Nail care should be done as needed for each client; nails grow at different rates for each person.

III. Observations to Make When Giving Nail Care **(II-5)**

A. Cuts

B. Callouses, corns

C. Changes in skin color

D. Complaints of tenderness

E. Swelling of feet and legs

F. The elderly client's nails may become thick, brittle, and difficult to trim.

G. Change in nail color - Nail may become black if there is a fungus infection or injury.

H. Hangnails and ingrown nails

IV. Specific Measures Related to Nail Care

A. Make sure you have a good source of light to enable you to see what you are doing.

B. Soaking the nails in water will make them softer. Trim nails straight across. Do not trim the nails too close to the flesh. Usually, clippers are used rather than scissors. Trimming the nails weekly makes the job easier. Shape and smooth nails with an emery board. (II-6)

C. Dry thoroughly between toes and fingers; excess moisture can lead to skin breakdown.

D. A licensed nurse or podiatrist should cut the toenails of a diabetic client since that client has poor circulation. A skin injury on the foot can cause infection. Always follow policies and procedures of your facility regarding trimming client's nails. (II-7, 8)

E. Ambulatory clients should wear good, supportive shoes and stockings, rather than house slippers.

F. Avoid use of garters. They restrict circulation. (II-9)

G. Incontinent clients who are confused or unconscious should have their fingernails cut short so that feces does not collect under the nails. Wash hands and clean under the nails if you see feces.

H. Always clean under the nails with an orange stick. (II-10)

V. Demonstrate Procedures for Nail Care

VI. Summary and Conclusion

A. Terminology

B. Purposes of nail care

C. Observations to make when giving nail care

D. Specific measures related to nail care

E. Review procedures for nail care.

The next lesson is on giving a backrub and skin care.

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR GIVING FINGERNAIL CARE:

1. Wash your hands.
2. Assemble necessary equipment.

   NOTE: This should include a supplementary light, if necessary, to provide a well-lit working area.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. If client is in bed, raise the backrest. Place disposable bed protector under the hands. Then, place towel on top of bed protector.
6. If client is in chair, lower overbed table; place table in front of client with disposable bed protector on top. Then, place towel on top of bed protector.
7. Place basin of warm, soapy water approximately 105°F on the towel.
8. Soak the fingers in the warm, soapy water for five minutes. Soak one hand at a time or soak both at the same time.
9. Rinse hands with clear, warm water and dry with the towel. Remove basin when finished soaking.
10. Place towel under client's dried hands.
11. Gently remove dirt from around and under each fingernail with an orange stick. Use paper towel to clean orange stick.
12. Trim nails (if needed) straight across.
13. Shape and smooth nails with an emery board.
14. Rub lotion on hands.
15. Repeat steps 9-14 on other hand.
16. Have client exercise hands by alternately stretching them and making a fist.
17. Make client comfortable; place call signal within reach, if needed.

BEST COPY AVAILABLE

18. Remove, clean, and store equipment.

19. Wash your hands.

20. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR GIVING TOENAIL CARE:

1. Wash your hands.

2. Assemble necessary equipment.

   NOTE: This should include a supplementary light, if necessary, to provide a well-lit working area.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. If possible, assist client out of bed into a chair.

6. Place bath mat on floor.

7. Fill basin with warm water.

8. Place basin of water on bath mat.

9. Assist client to place his/her feet in basin of warm water.

10. Soak feet to soften nails.

11. Wash feet with soap and water.

12. Rinse and dry feet.

13. Gently clean toenails with an orange stick.

14. If toenails are long and need to be cut, report to charge nurse or if facility policy allows, cut nails straight across top of the toe making certain the nail does not extend beyond the toe.

15. Apply lotion to feet.

16. Remove, clean, and store equipment.

17. Wash your hands.

18. Report reddened, irritated, callused areas, or breaks in the skin to charge nurse.

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What is the base of the fingernail called?
2. What are nails that grow in at the side called?
3. What is a physician who specializes in the care of the feet called?
4. What are two purposes of nail care?
5. What observations should the health care assistant make when doing nail care?
6. What is the proper way to trim nails?
7. Why does only the licensed nurse or podiatrist cut the toenails of a diabetic client?
8. What can happen to a skin injury on a diabetic client's foot?
9. Why should the use of garters be avoided?
10. What do you use to clean under the nail bed and around the nails?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates fingernail and toenail care.
2. Students practice fingernail and toenail care on each other.

ANSWERS TO EVALUATION ITEMS:

1. cuticle
2. ingrown nail
3. podiatrist
4. d
5. b
6. a
7. c
8. infection
9. b
10. d
11. d

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

1. The base of the fingernail is called the ____________________.

2. Nails that grow in at the side are called (two words) ____________________ ____________________.

3. A physician who specializes in the care of the feet is called a ____________________.

4. The purpose of nail care is: (Circle the letter of the best answer.)

   a. To meet state regulations.
   b. To prepare the nails for polish.
   c. To assist the nails to grow faster.
   d. To prevent infection from bacterial build up.

5. Which of the following is an observation to make and report when giving nail care? (Circle the letter of the best answer.)

   a. Pink and soft nails
   b. Change in skin color and ingrown nails
   c. The length of the nails before beginning care
   d. If the client enjoyed the procedure

6. Nails should be trimmed: (Circle the letter of the best answer.)

   a. Straight across.
   b. Close to the flesh.
   c. To a point in the center.
   d. Before soaking.

7. A licensed nurse or podiatrist should always trim the toenails of a diabetic client because diabetics have: (Circle the letter of the best answer.)

   a. Poor nutrition.
   b. Foot odor.
   c. Poor circulation.
   d. Swelling of their toes.

8. A skin injury of a client's foot who has diabetes may cause ____________________.

9. The use of garters should be avoided because they: (Circle the letter of the best answer.)

   a. Cause stockings to bag.
   b. Restrict circulation.
   c. Show when the client is sitting.
   d. Restrict movement.

10. The health care assistant cleans under the client's nails with: (Circle the letter of the best answer.)

   a. The tip of a bandage scissors.
   b. A finger nail file.
   c. An emery board.
   d. An orange stick.

11. It is important for the health care assistant to observe for the following when performing nail care: (Circle the letter of the best answer.)

   a. Callouses.
   b. Swelling of feet.
   c. Cuts.
   d. All of the above.

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:________________

GIVE FINGERNAIL CARE

EQUIPMENT:

1. Wash basin - 3/4 full of warm, soapy water
2. Pitcher of warm water
3. Towel and paper towel
4. Disposable/reusable bed protector
5. Orange stick/flat toothpick
6. Emery board
7. Nail clippers
8. Lotion

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment (including supplementary lighting, if necessary).		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. If client is in bed, raise the backrest. Place disposable bed protector under the hands. Then, place towel on top of bed protector.		
6. If client is in chair, lower overbed table; place table in front of client with disposable bed protector on top. Then, place towel on top of bed protector.		
7. Place basin of warm, soapy water approximately 105°F on the towel.		
8. Soak the fingers in the warm, soapy water for five minutes. Soak one hand at a time or soak both at the same time.		
9. Rinse hands with clear, warm water and dry with the towel. Remove basin when finished soaking.		
10. Place towel under client's dried hands.		

11.	Gently remove dirt from around and under each fingernail with an orange stick. Use paper towel to clean orange stick.		
12.	Trim nails (if needed) straight across.		
13.	Shape and smooth nails with an emery board.		
14.	Rub lotion on hands.		
15.	Repeat steps 9-14 on other hand.		
16.	Have client exercise hands by alternately stretching them and making a fist.		
17.	Make client comfortable; place call signal within reach, if needed.		
18.	Remove, clean, and store equipment.		
19.	Wash your hands.		
20.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE FINGERNAIL CARE" according to the steps outlined.

____ __________________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 25

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:________________

GIVE TOENAIL CARE

EQUIPMENT:

1. Wash basin - 3/4 full of warm, soapy water
2. Pitcher of warm water
3. Towel and paper towel
4. Disposable/reusable bed protector
5. Orange stick/flat toothpick
6. Emery board
7. Nail clippers
8. Lotion

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment NOTE: This should include a supplementary light, if necessary, to provide a well-lit working area.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. If possible, assist client out of bed into a chair.		
6. Place bath mat on floor.		
7. Fill basin with warm water.		
8. Place basin of water on bath mat.		
9. Assist client to place his/her feet in basin of warm water.		
10. Soak feet to soften nails.		
11. Wash feet with soap and water.		
12. Rinse and dry feet.		
13. Gently clean toenails with an orange stick.		

14. If toenails are long and need to be cut, report to charge nurse or if facility policy allows, cut nails straight across top of the toe making certain the nail does not extend beyond the toe.		
15. Apply lotion to feet.		
16. Remove, clean, and store equipment.		
17. Wash your hands.		
18. Report reddened, irritated, callused areas, or breaks in the skin to charge nurse.		

The student has satisfactorily completed the procedure "GIVE TOENAIL CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 26

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-26 AND DEMONSTRATION: VI-26

BACKRUB/SKIN CARE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Identify three purposes of backrub/skin care.
2. List observations to make while giving a backrub/skin care.
3. Identify specific measures related to backrub/skin care.

Demonstration

4. Give backrub according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Backrub Methods
2. HO 2: Which Nurse Assistant Are You?
3. Lotion
4. Bath towel (with bed bath)
5. Washcloth (with bed bath)
6. Basin with water (with bed bath)
7. Soap and soap dish (with bed bath)

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 26 (Student Reference page 405) and be prepared to discuss the information presented and return the demonstration of giving a backrub according to procedure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 12, Section 7.

INTRODUCTION:

Think about how good a backrub feels. We sometimes get so busy feeding, bathing, and toileting our clients that we tell ourselves we don't have time to give a backrub. Backrubs are important to our clients and can soothe, calm, and comfort them in a special way that no medicine can. A backrub may not seem an important part of your busy day, but to the client, a backrub means that his/her caregiver really does care.

The bedridden client should have a backrub and skin care at the time of each position change. Remember that the skin of the elderly is fragile and easily damaged. A backrub given improperly can cause discomfort, so be gentle. This lesson gives the procedure for giving a good backrub.

The Long-Term Care Executive Network, volume 1/number 7, January 1993, "Clinical Practice Guidelines" advises that bony prominences should not be massaged. Current evidence suggests that massage over bony prominences may be harmful. Rub around bony prominences.

LESSON PLAN: 26

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Purposes of Backrub/Skin Care (II-1)

- A. Stimulate circulation - a major aid in preventing skin break down
- B. Relax muscles and the client in general
- C. Relieve tension
- D. Opportunity to communicate with client

II. Specific Observations to Make While Giving a Backrub/Skin Care (II-2)

- A. Irritation/redness - reddened areas that do not blanch (whiten) when pressed
- B. Rashes
- C. Bruises
- D. Swelling
- E. Excessive dryness
- F. Sores, lumps, or growths
- G. Cuts, abrasions, burns
- H. Mottled (discoloration in irregular areas) skin that is cool to touch
- I. Check condition of skin over bony prominences. Report any break in skin.

III. Specific Measures Related to Backrub/Skin Care

- A. Oils or lotions are needed because the skin of the elderly is usually dry and needs the moisturizing effect of lotion.
- B. Before applying, warm the oil or lotion by placing it in a pan of warm water or rubbing a small amount in your palms. Apply lotion after bathing a client. (II-3)
- C. Powder is used to remove skin moisture at skin folds--any area where skin meets skin, under the breasts/large abdomen. Check facility policy for the use of powder. If powder is used, only use a light dusting to prevent caking.

(II-5, 6)

D. Do not shake powder over the client. He/she may inhale tiny powder particles and could develop irritation in the respiratory tract. Sprinkle powder in your hand and then apply it to the client's skin.

E. The elderly client must be handled with extreme gentleness to prevent bruising and tearing of the skin. (II-6)

F. The bedridden client must be repositioned at least every two hours, and the area around bony prominences should be massaged gently.

G. Backrub and skin care are given routinely as part of the bath, following use of bedpan, when changing the position of the helpless client, at bed time, and when it would be comfortable to the client.

H. Use long, smooth strokes to relax the client. (II-4)

IV. Demonstrate Procedure for Giving a Backrub.

V. Summary and Conclusion

A. Purposes of backrub/skin care

B. Specific observations to make while giving a backrub/skin care

C. Specific measures related to backrub/skin care

D. Review procedure for giving a backrub.

The next lesson is on dressing and undressing the client.

LESSON PLAN: 26

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR GIVING A BACKRUB:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Position client on the side of bed closest to you, then turn client on his/her side or assist into the prone position.
7. Place bath towel lengthwise close to client's back to protect bedding.
8. Wash, rinse, and dry back (if giving a bed bath or if the back is soiled).
9. Warm lotion, then apply to entire back. Begin at the base of the spine and with long, soothing strokes rub up the center, around the shoulders, and down the sides of the back and buttocks. Repeat four times.
10. Rub the buttocks with a circular motion until all lotion is absorbed into the skin.
11. Adjust bed covers and assist client to comfortable position.
12. Place call signal within reach, if needed.
13. Remove, clean, and store equipment.
14. Wash your hands.
15. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 26

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What are three purposes of the backrub?
2. What observations should the health care assistant make when giving a backrub?
3. How do you warm the lotion before applying it?
4. What type of movement is used to begin the backrub procedure?
5. Why is powder applied to the skin of the elderly?
6. When applying powder, why is only a light dusting used?
7. Why should elderly clients be handled gently?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates backrub procedure.
2. Students practice backrub procedure.
3. Have a class discussion of ways to prevent skin breakdown.

ANSWERS TO EVALUATION ITEMS:

1. b
2. The student may list any five of the following:
   a. Irritation/redness
   b. Rashes
   c. Bruises
   d. Swelling
   e. Excessive dryness
   f. Sores, lumps, or growths
   g. Cuts, abrasions, burns
   h. Mottled skin that is cool to touch
3. d
4. a
5. b
6. c
7. caking
8. bruising, tears

LESSON PLAN: 26

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

1. The purpose of the backrub is to: (Circle the letter of the best answer.)

   a. Increase tension.
   b. Relax muscles.
   c. Decrease circulation.
   d. Prevent contractures.

2. List five observations which the health care assistant should make while giving a backrub to a client:

   a.

   b.

   c.

   d.

   e.

3. Observations to make and report when giving a backrub are: (Circle the letter of the best answer.)

   a. Intact skin over bony prominences.
   b. If the client enjoyed the backrub.
   c. Position of the client.
   d. Rashes, break in skin, or abrasions.

4. The health care assistant should begin the backrub procedure with: (Circle the letter of the best answer.)

   a. Long, soothing movements.
   b. Fast stimulating movements.
   c. Light touching movements.
   d. Deep kneading massage.

5. Before beginning the backrub procedure, the lotion is: (Circle the letter of the best answer.)

   a. Held under the water faucet to warm.
   b. Placed in a pan of warm water to warm.
   c. Placed on the stove to warm.
   d. Shook well to make sure the lotion will pour easily.

6. Powder is applied to the skin of the elderly to: (Circle the letter of the best answer.)

   a. Moisten the skin.
   b. Make them smell nice.
   c. Remove skin moisture.
   d. Reduce room odors.

7. When powder is used, the health care assistant uses only a light dusting on the client's skin to prevent ____________________.

8. The elderly client should be handled gently to prevent ____________________ and skin ____________________.

LESSON PLAN: 26

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT: ______________

GIVE BACKRUB

EQUIPMENT:

1. Lotion
2. Bath towel (with bed bath)
3. Washcloth (with bed bath)
4. Basin with water (with bed bath)
5. Soap and soap dish

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Position client on the side of bed closest to you, then turn client on his/her side or assist into the prone position.		
7. Place bath towel lengthwise close to client's back to protect bedding.		
8. Wash, rinse, and dry back (if giving a bed bath or if the back is soiled).		
9. Warm lotion, then apply to entire back. Begin at the base of the spine and with long, soothing strokes rub up the center, around the shoulders, and down the sides of the back and buttocks. Repeat four times.		
10. Rub the buttocks with a circular motion until all lotion is absorbed into the skin.		
11. Adjust bed covers and assist client to comfortable position.		
12. Place call signal within reach, if needed.		
13. Remove, clean, and store equipment.		

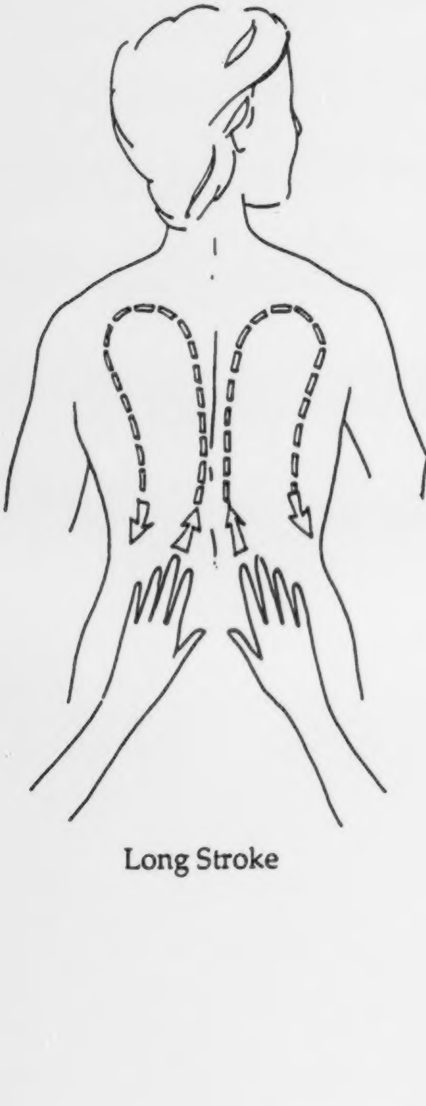
14. Wash your hands.		
15. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE BACKRUB" according to the steps outlined.

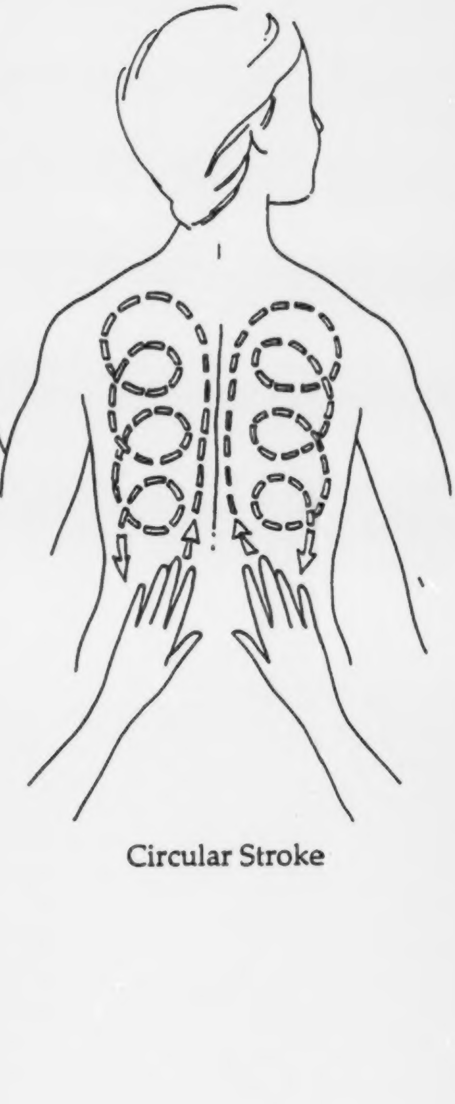
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

BACKRUB METHODS



Long Stroke



Circular Stroke

WHICH NURSE ASSISTANT ARE YOU?

NURSE ASSISTANT NUMBER ONE

She comes to my room all sad
and forlorn,
Acts like she wishes she had
never been born,
She shrugs her shoulders
And drops her head
As she tiresomely tugs
At the spread,

Then she says very weakly,
"Want a backrub tonight?"
I can't tire her further so
I say, "I'm alright."
Then she pats on my shoulder
And says with a grin
How much she adores me, what a
Good patient I've been.
Then she slides from the room,
Out into the night,
Hoping all of her patients
Will say, "I'm alright."

NURSE ASSISTANT NUMBER TWO

My weary little room
She hits like a breeze,
Smiling and talking and
Wanting to please.
"It's backrub time, Mrs. Smith,
Turn over, let's go."
Then she has me face downward
'Fore I can say no.

Then she tugs at my linens till
They're smooth and neat.
She fluffs up my pillow...
That's always a treat.
Those little uncharted things that
Doctors don't see
Are always remembered by sick
Folks like me.

When I'm healthy
And home again,
You know what I'll do...
I'll always remember
Nurse Assistant Number Two.

Author Unknown

LESSON PLAN: 27

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-27 AND DEMONSTRATION: VI-27

DRESSING AND UNDRESSING
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Identify five key points of dressing and undressing.

Demonstration

2. Assist the client to dress according to the steps of procedure.
3. Assist the client to undress according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Articles of clothing appropriate for proper dress of client
2. HO 1: Self-Help Aids for Grooming and Hygiene
3. HO 2: Self-Help Aids for Dressing

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 27 (Student Reference page 413) and be prepared to discuss the information presented and return the demonstration on dressing and undressing the client.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 23.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 22, Section 5.

Sorrentino, Shelia. Textbook for Nursing Assistant, 3rd ed. St. Louis, MO: Mosby, 1991. Chapter 19.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6, Section 4.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990, Chapter 11.

DePoy, Elizabeth; Lynn Archer. "Topics in Geriatric Rehabilitation". Volume 7, Number 4, June 1992.

INTRODUCTION:

This lesson applies to clients in long-term care and residential care facilities. Although some the procedures may also pertain to clients in acute care facilities.

An essential part of good grooming is wearing appropriate, clean, and neat clothing. Allow the client to choose what to wear. If the client has difficulty making decisions, don't open the closet and expect him/her to pick something out. Rather, suggest two different outfits and let him/her choose one. This allows the client to make some decisions. The client, because of illness and disability, may not be able to get dressed independently. You, as a health care assistant, will then be responsible for dressing the client. Remember the importance of allowing the client to do anything that he/she can. This will reduce feelings of being so dependent upon others.

A recent article published in "Topics in Geriatric Rehabilitation" describes environmental confinement of clients. An example of environmental confinement in the article was "not putting shoes, socks, stockings, and under clothing on client who required assistance with dressing in long-term care facilities."

LESSON PLAN: 27

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Key Points of Dressing and Undressing

A. Supervise appropriate dress depending upon weather and occasion. Remember the elderly have poorer circulation, less fat, and are less active; thus, they may complain of feeling cold even if you are warm. Dress client as he/she requests.

B. Assure complete dress for ambulatory clients and for those up in a chair or wheelchair (II-1)

1. Underwear - bra and panties or T-shirt and shorts

2. Shoes and stockings - important for the elderly to have both on for warmth and proper support

3. Sweaters and jackets - appropriate for many clients even in the summer since they may feel colder

4. Lap robe - for clients in a wheelchair and with a catheter

C. Dress with clean clothes after bathing and at any time clothing is soiled. (II-2)

D. Encourage clothes that open down the front for handicapped clients.

E. Do not put clothes on backwards. This is not appropriate.

F. Be aware of those clients whose families do their laundry. Place soiled clothes in proper hamper.

G. All personal clothing should have name tags sewn in or should be marked with ink that will not wash out. Avoid marking where name will show. (II-3)

H. Send clothing to appropriate department if it needs to be mended. Clients should not have to wear clothing that is in need of repair.

I. If the client has a non-functioning weak side, you dress the arm of the weak side first. (II-4)

J. The dependent client can be completely dressed in bed before he/she is transferred to a chair. (II-5)

K. Always put on clients' shoes before having them stand up. This helps prevent them from slipping. (II-6)

L. After undressing a client and putting him/her to bed, make certain the call light is within reach. (II-7)

M. If prescribed, apply circulatory stockings before getting the client out of bed.

II. Demonstrate Procedures for Dressing and Undressing the Client.

III. Summary and Conclusion

A. Key points of dressing and undressing

B. Review procedures for dressing and undressing the client.

The next lesson is on applying heat and cold treatments.

LESSON PLAN: 27

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR ASSISTING CLIENT TO DRESS:

1. Wash your hands.
2. Assemble necessary clothing.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Assist client in removing gown, pajamas, or soiled clothing.
7. If client is in bed, put on underclothes, stockings, and slacks while lying down.
8. Brassiere
   a. If client can assist, place around her chest so fasteners are in front; fasten bra.
   b. Shift it around so fasteners are in back.
   c. Instruct client to slip arms through the shoulder straps.
9. Undershirt/slip
   a. Assist or have client put arms into undershirt/slip first.
   b. Assist or have client put head into undershirt/slip.
   c. Check and make sure undershirt/slip does not remain rolled up on client's back--pull down to waist.
10. Stockings/socks
    a. Roll the stocking down from the opening to just beyond the heel.
    b. Support client's ankle and slip rolled stocking over the toes; position it over the heel, and pull it up smoothly over the leg.
11. Underpants/slacks/pants
    a. Put both legs in pants; slide up to hips.

b. Have client lift his/her hips and pull pants up. If client is unable to, turn to one side and slip pants over hip, then turn to opposite side and pull pants over hip.

c. Zip the zipper and fasten (if applicable).

d. If client has catheter, leave the fly open to allow for tubing, then pin the fly shut.

12. Shoes

    a. Always help client put shoes on before standing up from bed to avoid slipping on floor.

    b. Loosen laces and pull tongue of shoe forward and up.

    c. Support client's ankle as you slide the toes, foot, and heel into the shoe.

       NOTE: Use a shoehorn, if available.

    d. If possible, have client stand and then tie shoelaces.

13. Raise the head of the bed to a near sitting position; or assist client into a sitting position on side of bed or into a chair at bedside.

14. Dress/shirt

    a. Assist or have client put weak arm in sleeve of garment first while there is more "give".

    b. Put other arm in next.

    c. If both arms are weak, put dress on over feet, then put arms in sleeves.

15. Pullover sweater/shirt is put on like undershirt.

16. Hang clean clothes like sweaters in closet. Place soiled garments in appropriate container.

17. Wash your hands.

18. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR ASSISTING CLIENT TO UNDRESS:

1. Wash your hands.

2. Assemble necessary clothing.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.
5. Provide privacy.
6. Assist client from chair to the bed; if he/she is able, have client sit on side of bed. If unable, help client to lie down.
7. Remove shoes (if client will be lying down).
    a. Loosen shoelaces, pull tongue of shoe forward and up.
    b. Support ankle and slide foot out of shoe.
    c. Store shoes in closet.
8. Remove stockings.
    a. Roll stocking down to ankle.
    b. Support ankle and slide stocking off foot.
9. Pullover sweater/shirt
    a. Loosen first (unzip/unbutton) and grasp the bottom of garment at back and pull to the neck.
    b. Pull over head.
    c. Then pull garment off the arms.
10. Dress/shirt
    a. Loosen first and remove the sleeve of garment from the strong arm.
    b. If client is lying down, then roll client and tuck the half-removed garment under client.
    c. Return client to back; turn him/her slightly in the opposite direction; grasp the garment and pull out.
    d. Remove garment from weak arm.
    e. Follow same sequence if client is sitting up.
11. Slacks/pants/underpants
    a. Unfasten pants at waist and unzip.
    b. Have client stand if able and pull pants off legs.

c. If client is lying down, have him/her lift hips up and slip pants down over buttocks. If client is unable to do this, roll client toward you, slip pants down over hip, then turn to back and to opposite side and pull pants down over other hip.

d. Return client to back and slide pants down over legs and pull pants over feet.

e. Remove shoes and stockings if client was standing.

12. Undershirt/slip is removed following the same steps as for pullover sweater/shirt.

13. Brassiere

    a. Unfasten bra/assist client to unfasten bra.

    b. Slip arms out of shoulder straps.

14. Hang clean clothes like sweaters neatly in the closet. Place soiled garments in appropriate container.

15. Wash your hands.

16. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 27
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT VI : THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What clothing is included in complete dress?
2. When is the client's clothing changed?
3. How do you identify the client's clothing?
4. Which arm should be placed in garments first if the client has a nonfunctioning or weak side?
5. What clothes can you put on the client before he/she sits up?
6. Why do you have the client put on shoes before standing?
7. What should always be done after the client has been undressed and put into bed?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates dressing and undressing a client. (May have a student put on clothing over his/her own clothing if Chase doll is not available.)
2. Students practice dressing and undressing procedures.
3. Put vaseline on eye glasses and have students wear the glasses while trying to dress.

ANSWERS TO EVALUATION ITEMS:

1. b
2. c
3. b
4. a
5. d
6. slipping
7. c

LESSON PLAN: 27

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

1. Complete dress in a long-term care or residential care facility includes: (Circle the letter of the best answer.)
    a. House slippers, shirt, pants, blouse, dress or skirt.
    b. Underwear, shoes, stockings, shirt, pants, blouse, dress or skirt.
    c. Robe gown, pajamas, slippers.
    d. Whatever is available to dress the client.

2. In a long-term care or residential care facility, the client's clothing is changed: (Circle the letter of the best answer.)
    a. When the bed is changed.
    b. When relatives come for dirty clothing.
    c. When soiled and after bathing.
    d. When the state inspectors are coming for a visit.

3. The client's clothing should be: (Circle the letter of the best answer.)
    a. Put on backwards to provide more privacy.
    b. Labeled with sewn in name tags or ink that doesn't wash out.
    c. Labeled with markers where the name will show on the outside of the garment.
    d. Shared with another client who doesn't have nice clothing.

4. When dressing a client whose left side is paralyzed, the nurse should: (Circle the letter of the best answer.)
    a. Put the left arm into the sleeve first.
    b. Put the right arm into the sleeve first.
    c. Put both arms into the sleeves at the same time.
    d. Put the head through the opening of shirt or blouse and then pull over both arms.

5. Mrs. Farley is a dependent client in long-term care who is to be dressed by 8:00 a.m. for breakfast in the dining room. Which one of the following would be correct procedure for dressing Mrs. Farley? (Circle the letter of the best answer.)

   a. Put the robe and slippers on after standing her at the side of the bed.
   b. Since she is dependent, ask another health care assistant to assist you in dressing her.
   c. Put her slippers on after transferring her to a chair.
   d. Completely dress her in bed before transferring her to a chair.

6. Shoes are put on a client before having him/her stand to prevent him/her from ______________________.

7. After undressing the client and putting him/her to bed, the health care assistant should: (Circle the letter of the best answer.)

   a. Place the bedpan within reach.
   b. Remove the wheelchair from the room.
   c. Make certain the call light is within reach.
   d. Chart that he/she was undressed.

LESSON PLAN: 27

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:______________

ASSIST CLIENT TO DRESS

EQUIPMENT:

1. Articles of clothing appropriate for proper dress of client.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary clothing.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Assist client in removing gown, pajamas, or soiled clothing.		
7. If client is in bed, put on underclothes, stockings, and slacks while lying down.		
8. Brassiere a. If client can assist, place around her chest so fasteners are in front; fasten bra.		
b. Shift it around so fasteners are in back.		
c. Instruct client to slip arms through the shoulder straps.		
9. Undershirt/slip a. Assist or have client put arms into undershirt/slip first.		
b. Assist or have client put head into undershirt/slip.		
c. Check and make sure undershirt/slip does not remain rolled up on client's back--pull down to waist.		
10. Stockings/socks a. Roll the stocking down from the opening to just beyond the heel.		
b. Support client's ankle and slip rolled stocking over the toes; position it over the heel, and pull it up smoothly over the leg.		

11. Underpants/slacks/pants a. Put both legs in pants; slide up to hips.		
b. Have client lift his/her hips and pull pants up. If client is unable to, turn to one side and slip pants over hip, then turn to opposite side and pull pants over hip.		
c. Zip the zipper and fasten the snap\button (if applicable).		
d. If client has catheter, leave the fly open to allow for tubing, then pin the fly shut.		
12. Shoes a. Always help client put shoes on before standing up from bed to avoid slipping on floor.		
b. Loosen laces and pull tongue of shoe forward and up.		
c. Support client's ankle as you slide the toes, foot, and heel into the shoe.		
d. If possible, have client stand and then tie shoelaces.		
13. Raise the head of the bed to a near sitting position; or assist client into a sitting position on side of bed or to a chair at bedside.		
14. Dress/shirt a. Assist or have client put weak arm in sleeve of garment first while there is more "give."		
b. Put other arm in next.		
c. If both arms are weak, put dress on over feet, then put arms in sleeves.		
15. Pullover sweater/shirt is put on like undershirt.		
16. Hang clean clothes like sweaters in closet. Place soiled garments in appropriate container.		
17. Wash your hands.		
18. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ASSIST CLIENT TO DRESS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 27

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:_______________

ASSIST CLIENT TO UNDRESS

EQUIPMENT:

1. Gown or pajamas

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Arrange necessary clothing.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Assist client from chair to the bed; if he/she is able, have client sit on side of bed. If unable, help client to lie down.		
7. Remove shoes (if client will be lying down). a. Loosen shoelaces, pull tongue of shoe forward and up.		
b. Support ankle and slide foot out of shoe.		
c. Store shoes in closet.		
8. Remove stockings a. Roll stocking down to ankle.		
b. Support ankle and slide stocking off foot.		
9. Pullover sweater/shirt a. Loosen first (unzip/unbutton) and grasp the bottom of garment at back and pull on the neck.		
b. Pull over head.		
c. Then pull garment off the arms.		
10. Dress/shirt a. Loosen first and remove the sleeve of garment from the strong arm.		

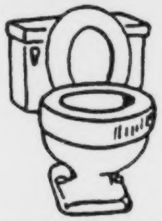
b. If client is lying down, then roll client and tuck the half-removed garment under client.		
c. Return client to back; turn him/her slightly in the opposite direction; grasp the garment and pull out.		
d. Remove garment from weak arm.		
e. Follow same sequence if client is sitting up.		
11. Slacks/pants/underpants a. Unfasten pants at waist and unzip.		
b. Have client stand if able and pull pants off legs.		
c. If client is lying down, have him/her lift hips up and slip pants down over buttocks. If client is unable to do this, roll client toward you, slip pants down over hip, then turn to back and to opposite side and pull pants down over other hip.		
d. Return client to back and slide pants down over legs and pull pants over feet.		
e. Remove shoes and stockings if client was standing.		
12. Undershirt/slip is removed following the same steps as for pullover sweater/shirt.		
13. Brassiere a. Unfasten bra/assist client to unfasten bra.		
b. Slip arms out of shoulder straps.		
14. Hang clean clothes like sweaters in closet. Place soiled garments in appropriate container.		
15. Wash your hands.		
16. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ASSIST CLIENT TO UNDRESS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

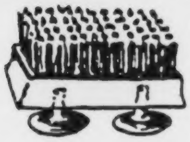
Date

SELF-HELP AIDS FOR GROOMING AND HYGIENE



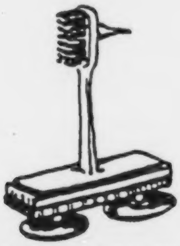
RAISED TOILET LID

Permits ease in getting off toilet when legs are weak. Limits hip flexion. Eases transfer from a wheel chair.



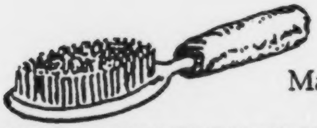
SUCTION-CUP FINGERNAIL BRUSH

Assists the client with loss of use of one hand to maintain cleanliness.



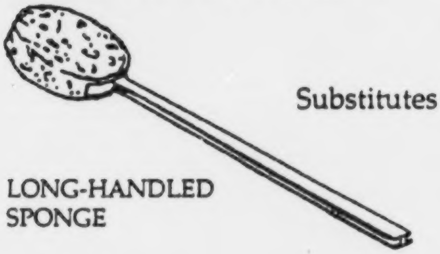
SUCTION-CUP DENTURE BRUSH

Allows one-handed cleaning of dentures. Suctions onto sink.



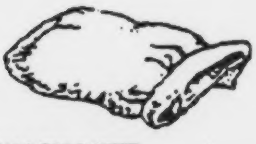
BUILT-UP HANDLE HAIR BRUSH

Makes holding brush easier and more comfortable.



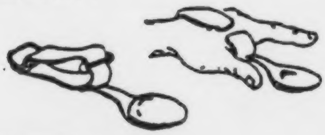
LONG-HANDLED SPONGE

Substitutes for limited strength and range.



WASH MITT

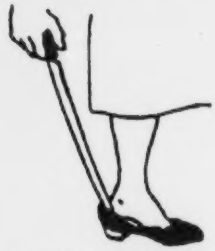
Used when hand grasp is too limited to hold a washcloth.



UNIVERSAL CUFF

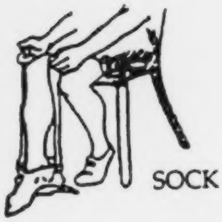
Substitutes for hand grasp. Can be adapted to hold toothbrush, razor, comb, brush, etc.

SELF-HELP AIDS FOR DRESSING



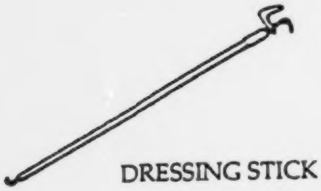
LONG-HANDLED SHOE HORN

Substitutes for lack of range in arms and trunk. Used if client is unable to bend over safely.



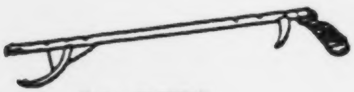
SOCK AID

Used when hip range is limited or arm/hand strength is poor.



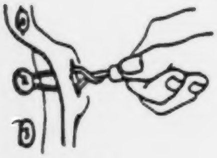
DRESSING STICK

Compensates for limited reach or muscle weakness. Used to pull clothing over feet or to reach hangers in closet.



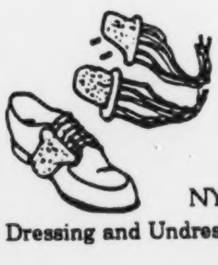
REACHERS

Compensates for limited reach or muscle weakness. Used to start clothing over body parts, remove clothes from shelves, or pick up objects from floor.



BUTTON AID

Used when fingers are unable to manipulate the button to fasten it.



NYLON TAPE FASTENENER (Velcro®) SHOE CLOSURE

Adaptation for lack of ability to tie shoes due to loss of use of one hand, poor trunk control, or limitation in hip range.

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit, Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-28 AND DEMONSTRATION: VI-28

APPLYING HEAT AND COLD
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms in this lesson with their correct definitions.
2. Identify the purpose of applying heat.
3. List three uses for heat application.
4. Identify three types of heat application.
5. Identify signs of complications of heat application.
6. Identify the purpose of applying cold.
7. List three uses for cold application.
8. Identify three types of cold applications.
9. Identify signs of complications of cold application.
10. Identify safety measures to follow when applying heat and cold.

Demonstration

11. Apply warm, moist compress according to the steps of procedure.
12. Apply aquamatic K-pad according to the steps of procedure.

13. Apply a warm water bottle according to the steps of procedure.

14. Apply an ice bag/ice cap according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Applying a Warm, Moist Compress
2. Hot water bottle
3. Aquamatic K-pad
4. Ice bag/ice cap
5. Ice
6. Basin
7. Bath thermometer
8. Compress - small towel, washcloth, or gauze squares
9. Plastic wrap
10. Ties, tape, or rolled gauze
11. Bath towels
12. Waterproof bed protector
13. Warm water bottle
14. Cover (flannel)
15. Water - 100° to 115°F
16. Graduate
17. Distilled water

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 28 (Student Reference page 423) prior to class and be prepared to discuss the information presented and return the demonstrations on applying heat and cold.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 25, Section 9.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6, Section 5.

INTRODUCTION:

Applications of heat and cold are ordered by the physician to promote healing and comfort and to reduce swelling. Heat and cold have opposite effects on the blood vessels. Applying heat/cold may be a responsibility of the health care assistant. If so, it is important to keep in mind some basic principles and safety precautions in order to avoid injury to or discomfort for the client. When a heat or cold application is used, the client's skin should be checked for signs of complications. First, check after the initial five minutes of application, then, continue checking every 30 minutes until treatment is discontinued.

The health care assistant must monitor the client during heat applications to prevent the client from becoming burned. The health care assistant will only apply a warm, moist compress if the client's skin is intact, and it is not considered a sterile procedure. If a sterile compress is ordered, the charge nurse would need to apply it. When applying a warm water bottle, the water should be between 100°F and 115°F. If the water is too hot, it may burn the client.

When applying cold applications, the health care assistant must keep in mind the safety and comfort of the client. Since frostbite and damage to the lower body tissues could result from too long an application, it becomes necessary to observe the client's skin condition. Cold applications should be discontinued at two-hour intervals or as the physician's order.

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Terminology (II-1)

   A. Local heat application - heat is applied to a body part

   B. Constrict - to narrow

   C. Dilate - to expand or open wider

   D. Cyanosis - bluish discoloration of the skin

   E. Moist application - water is in contact with the skin

   F. Dry application - water is not in contact with the skin

   G. Hot soak - putting the body part into a container of water

   H. Sitz bath - immersing the pelvic area in warm water for 20 minutes

   I. Ice bag - a dry cold application

II. Purpose of Heat Application (II-2)

   A. The purpose of heat is to cause the blood vessels to dilate where applied; more blood flow increases the amount of oxygen and nutrients to the area, which promotes tissue healing. Dilation of blood vessels also speeds up removal of waste products, poisonous substances, and excess fluid from the area.

III. Uses of Heat Application (II-3)

   A. Relieve pain, as in muscular spasm, by relaxing muscles

   B. Reduce inflammation

   C. Provide warmth and comfort

IV. Types of Heat Application

   A. Warm compresses - moist heat

   B. Warm water bottle - many facilities have discontinued the use of warm water bottles.

1. Dry heat
2. Check bag for leaks before applying
3. Fill 2/3 full
4. Expel air
5. Cover with flannel bag before applying

C. Heating pad - this dry heat application is seldom used with elderly.

D. Warm soaks - moist heat

E. Aquamatic K-pad - dry application, check every hour or according to the needs of the client

V. Complications of Heat Applications (II-4)

A. Burns - danger signs include:

1. Redness
2. Pain
3. Blisters

B. Tissue damage

1. When heat is applied for a long time, blood vessels tend to constrict or narrow.
2. This causes less blood flow to area.
3. The decreased blood flow causes tissue damage and the skin will appear pale.

C. Persons at the greatest risk for complications

1. Elderly - their skin is very delicate and fragile
2. Those who have interference with feelings of sensation which include
    a. Circulatory disorders
    b. Central nervous system damage
    c. Aging
    d. Loss of consciousness

D. Confused client

E. Those receiving strong pain medication

VI. Purpose of Cold Application (II-5)

A. The purpose of cold is to cause the blood vessels to constrict where applied; less blood flow decreases the amount of oxygen and nutrients to the area which will reduce the amount of toxic substances and waste products produced.

VII. Uses of Cold Application (II-6)

A. Reduces pain, which has a numbing effect

B. Prevents swelling

C. Cools the body when fever is present

D. Controls bleeding

VIII. Types of Cold Application (II-7)

A. Cold compresses - moist cold

B. Cold sponge bath - moist cold

C. Ice bag

1. Dry cold

2. Check for leaks before filling

3. Use crushed ice to fill the bag 2/3 full (it can be molded to the client's body part)

4. Should be placed in a flannel covering

5. First, check after the initial five minutes of application, then continue checking every 30 minutes until treatment is discontinued.

6. Wait one hour and then reapply

IX. Complications of Cold Application (II-8)

A. Cold temperatures can result in tissue damage

B. Signs that indicate tissue damage

1. Pain

2. Cyanosis

3. Burns and blisters from intense cold

X. Safety Measures to Follow When Applying Heat/Cold (II-9)

A. Always check the temperature of a solution by using a thermometer or the inner aspect of your lower arm. It is difficult to control the temperature of water.

B. Check any type of electrical device to be sure the temperature control is properly set and that there are no frayed cords.

C. Make sure you know how to operate the equipment required for the procedure; if not, ask the charge nurse for instructions.

D. When a heat or cold application is used, the client's skin should be checked for signs of complications. First, check after the initial five minutes of application, then, continue checking every 30 minutes until treatment is discontinued. If any signs indicate complications, discontinue the treatment at once and notify the charge nurse.

E. Know how long the application is to be left in place and carefully monitor the time.

F. Expose only the body part where the heat/cold is to be applied.

G. Make sure the signal light is within easy reach of the client.

H. Remember elderly persons have a decreased perception of temperature which increases the risk of burning.

I. Remember the weight of the bottle can create additional pressure on an already injured or damaged area.

J. Most facilities have policies excluding the use of electric heating pads.

K. Current research shows that a heat lamp slows down the healing process of pressure sores.

L. Any hot or cold appliance which is permanently set should not be changed.

XI. Demonstrate Procedures for Applying Heat and Cold. (II-10 - 14)

XII. Summary and Conclusion

A. Terminology

B. Purpose of heat application

C. Uses of heat application

D. Types of heat application

E. Complications of heat application

F. Purpose of cold application

G. Uses of cold application

H. Types of cold application

I. Complications of cold application

J. Safety measures to follow when applying heat/cold

K. Review procedures for applying heat and cold.

The next lesson is on preventing and caring for decubitus ulcers.

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE APPLYING A WARM, MOIST COMPRESS:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Position client in a comfortable position.
7. Place waterproof bed protector under the body part that is to receive moist compress.
8. Fill basin 1/2 to 2/3 full with hot water that is 105° to 115°F.
9. Place compress into hot water.
10. Wring out compress so water is not dripping from it.
11. Apply to specified area and note time of application.
12. Cover compress with a plastic wrap and then with a bath towel.
13. Secure towel in place with ties, tape, or rolled gauze.
14. Make sure signal light is within reach; check area after initial five minutes.
15. Remove moist compress after 20 minutes; pat dry with a towel.
16. Remove, clean, and store equipment.
17. Wash your hands.
18. Make the client comfortable; place call signal within reach.
19. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR APPLYING AQUAMATIC K-PAD:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Place pad in cover. DO NOT USE PINS!
7. Place container on bedside table.
8. Arrange tubing at the level of the pad. Do not allow tubing to hang below the level of the bed.
9. Very carefully and gently apply pad to body area. Note time the pad is applied.
10. Check skin under pad every hour.
11. Remove aquamatic K-pad at the end of the treatment period.
12. Remove, clean, and store equipment.
13. Make the client comfortable; place call signal within reach.
14. Wash your hands.
15. Record time applied, length of treatment, the area to which it is applied, and any unusual observations.

STEPS OF PROCEDURE APPLYING A WARM WATER BOTTLE:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Rinse warm water bottle with hot tap water; test for leaks.
7. Fill graduate with warm water and test temperature with bath thermometer (110° - 115°F).

8. Pour warm water into bag until approximately 1/2 full.

9. Expel air from bottle.

10. Close opening.

11. Dry top and neck of bottle.

12. Apply flannelette cover or wrap in dry towel to prevent burns and to secure in place.

13. Apply as ordered.

14. Record time, temperature of water, and area to which it is applied.

15. Make sure signal light is within the client's reach. Check client's skin area and dryness of warm water bottle cover after the initial five minutes and every 30 minutes thereafter to prevent burns.

16. Remove, clean, and store equipment.

    a. Dry inside and outside of bottle.

    b. Store inflated in cool place.

17. Wash your hands.

18. Make client comfortable; place call signal within reach.

19. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE APPLYING AN ICE BAG/ICE CAP:

1. Wash your hands.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Test equipment for leaks by filling with water.

   NOTE: This is done outside the client's room, usually in the clean utility room.

7. Use clean basin and scoop or spoon to collect ice.

8. Fill ice cap or ice bag 1/2 to 2/3 full.

9. Expel all air.

10. Dry outside of bag or cap. If moisture is left on the bag, it may penetrate and cause injury.

11. Apply cover (fitted wrapper or towel pinned around equipment).

12. Apply against indicated area.

13. Check the client's skin for signs of complications after the first five minutes; then, continue checking every 30 minutes until treatment is discontinued.

14. Remove cap or bag when time has elapsed.

15. Discontinue application at two-hour intervals or per physician's order.

16. Remove, clean, and store equipment.
    a. Dry exterior.
    b. Hang upside-down with cap open.
    c. Store appliance inflated and closed in a cool place after drying.

17. Wash your hands.

18. Make client comfortable; place call signal within reach.

19. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What are the definitions of terms used in this lesson?
2. What is the purpose of applying heat?
3. What are three uses for heat application?
4. What is the major complication from applying heat?
5. What is the purpose of cold application?
6. What four conditions indicate the use of cold applications?
7. What are three types of cold applications?
8. What are the signs of complications from cold application?
9. What safety measures should be followed when applying heat/cold?
10. What is the correct water temperature for a warm, moist compress?
11. How full do you fill an ice bag?
12. How long is a warm, moist compress left on?
13. What is the correct water temperature for a warm water bottle?
14. How full do you fill a warm water bottle?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show types of equipment used to apply heat/cold.
2. Instructor demonstrates applying warm, moist compress.
3. Students practice applying warm, moist compress.
4. Instructor demonstrates applying warm water bottle.
5. Students practice applying warm water bottle.

6. Instructor demonstrates applying an aquamatic K-pad.

7. Students practice applying an aquamatic K-pad.

8. Instructor demonstrates applying an ice bag/ice cap.

9. Students practice applying an ice bag/ice cap.

ANSWERS TO EVALUATION ITEMS:

1. d
2. b
3. e
4. g
5. f
6. a
7. a

8. a. Relieve pain by relaxing muscles
   b. Reduce inflammation
   c. Provide warmth and comfort

9. d
10. b
11. b

12. a. Reduce pain - numbing effect
    b. Prevent swelling
    c. Cool the body when fever is present

13. d
14. d
15. d
16. T
17. T
18. T
19. b
20. d
21. a
22. b
23. c

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

		Column I		Column II
____	1.	Ice bag	a.	The water is in contact with the skin
____	2.	Local heat application	b.	Heat is applied to a body part
____	3.	Dilate	c.	Water is not in contact with the skin
____	4.	Constrict	d.	A dry cold application
____	5.	Cyanosis	e.	To expand or open wide
____	6.	Moist application	f.	Bluish discoloration of the skin
			g.	To narrow

7. The purpose of heat is to: (Circle the letter of the best answer.)

   a. Dilate blood vessels; increase blood flow
   b. Dilate blood vessels; decrease blood flow
   c. Constrict blood vessels; increase blood flow
   d. Constrict blood vessels to stop blood flow

8. List three uses for heat.

   a.

   b.

   c.

9. Heat can be applied by which of the following methods? (Circle the letter of the best answer.)

   a. Aquamatic K-pad
   b. Hot water bottle
   c. Heating pad
   d. All of the above

10. Which of the following is NOT a sign that would indicate a complication of heat application? (Circle the letter of the best answer.)

   a. Reddened appearance
   b. Chilling
   c. Blisters
   d. Pain at the site

11. The purpose of cold is to: (Circle the letter of the best answer.)

   a. Dilate blood vessels; increase blood flow.
   b. Constrict blood vessels; decrease blood flow.
   c. Constrict blood vessels; increase blood flow.
   d. Dilate blood vessels; decrease blood flow.

12. List three uses for cold application.

   a.

   b.

   c.

13. Which of the following is NOT a method of applying cold application? (Circle the letter of the best answer.)

   a. Cold compresses
   b. Ice bag
   c. Cold sponge bath
   d. Tepid bath

14. Which of the following is NOT a sign that would indicate a complication of cold? (Circle the letter of the best answer.)

   a. Pain
   b. Cyanosis
   c. Blisters
   d. Bruising

15. When a heat or cold application is used the client's skin should be checked: (Circle the letter of the best answer.)

   a. After the initial 30 minutes and then every hour until the treatment is discontinued.
   b. After the initial one (1) hour and every hour until the treatment is discontinued.
   c. Every five minutes while the treatment is being given.
   d. First check after the initial five minutes of application and continue every 30 minutes until the treatment is discontinued.

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 16. Never apply a solution for heat and cold application without checking the temperature first.

____ 17. Expose only the area to be treated with heat/cold.

____ 18. Make sure the signal light is within easy reach of the client when applying heat/cold.

19. The temperature of the water for a warm, moist compress should be: (Circle the letter of the best answer.)

    a. 120°F to 125°F.
    b. 105°F to 115°F.
    c. 85°F to 100°F.
    d. 95°F to 100°F.

20. How full is an ice bag filled? (Circle the letter of the best answer.)

    a. To the top of the bag
    b. 1/4 full
    c. 1/3 full
    d. 1/2 to 2/3 full

21. How long is a warm, moist compress left on the client? (Circle the letter of the best answer.)

    a. 20 minutes
    b. 40 minutes
    c. 50 minutes
    d. 1 hour

22. What is the water temperature for a warm water bottle? (Circle the letter of the best answer.)

    a. 95°F to 100°F
    b. 110°F to 115°F
    c. 120°F to 130°F
    d. 75°F to 85°F

23. How full should a warm water bottle be filled? (Circle the letter of the best answer.)

    a. 1/3 full
    b. 3/4 full
    c. 1/2 full
    d. 1/4 full

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT: ________________

APPLY WARM, MOIST COMPRESS

EQUIPMENT:

1. Basin
2. Bath thermometer
3. Compress - small towel, washcloth, or gauze squares
4. Plastic wrap
5. Ties, tape, or rolled gauze
6. Bath towel
7. Waterproof bed protector
8. Water

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Position client in a comfortable position.		
7. Place waterproof bed protector under the body part that is to receive moist compress.		
8. Fill basin 1/2 to 2/3 full with hot water that is 105° to 115°F.		
9. Place compress into hot water.		
10. Wring out compress so water is not dripping from it.		
11. Apply to specified area and note time of application.		
12. Cover compress with a plastic wrap and then with a bath towel.		
13. Secure towel in place with ties, tape, or rolled gauze.		
14. Make sure signal light is within reach; check area after initial five minutes.		
15. Remove moist compress after 20 minutes; pat dry with a towel.		

16.	Remove, clean, and store equipment.		
17.	Wash your hands.		
18.	Make the client comfortable; place call signal within reach.		
19.	Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "APPLY WARM, MOIST COMPRESS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

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LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT: ______________

APPLY AQUAMATIC K-PAD

EQUIPMENT:

1. Aquamatic K-pad
2. Distilled water
3. Covering for pad

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Place pad in cover. DO NOT USE PINS!		
7. Place container on bedside table.		
8. Arrange tubing at the level of the pad. Do not allow tubing to hang below the level of the bed.		
9. Very carefully and gently apply pad to body area. Note time the pad is applied.		
10. Check skin under pad every hour.		
11. Remove aquamatic K-pad at the end of treatment period.		
12. Remove, clean, and store equipment.		
13. Make the client comfortable; place call signal within reach.		
14. Wash your hands.		
15. Record time applied, length of treatment, the area to which it is applied, and any unusual observations.		

The student has satisfactorily completed the procedure "APPLY AQUAMATIC K-PAD" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT: ______________

APPLY WARM WATER BOTTLE

EQUIPMENT:

1. Warm water bottle
2. Cover (flannel)
3. Towel
4. Bath thermometer
5. Water - 110° to 115°F
6. Graduate

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Rinse warm water bottle with hot tap water; test for leaks.		
7. Fill graduate with warm water and test temperature with bath thermometer (110°-115°F).		
8. Pour warm water into bag until approximately 1/2 full.		
9. Expel air from bottle.		
10. Close opening.		
11. Dry top and neck of bottle.		
12. Apply flannelette cover or wrap in dry towel to prevent burns and to secure in place.		
13. Apply as ordered.		
14. Record time, temperature of water, and area to which it is applied.		

15. Make sure signal light is within the client's reach. Check client's skin area and dryness of warm water bottle cover after the initial five minutes and every 30 minutes thereafter to prevent burns.		
16. Remove, clean, and store equipment.		
a. Dry inside and outside of bottle.		
b. Store inflated in cool place.		
17. Wash your hands.		
18. Make client comfortable; place call signal within reach.		
19. Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "APPLY WARM WATER BOTTLE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 28

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

NAME OF STUDENT: ______________

APPLY ICE BAG/ICE CAP

EQUIPMENT:

1. Ice cap or ice bag and wrapper
2. Basin
3. Scoop or spoon
4. Ice

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Test equipment for leaks by filling with water. NOTE: This is done outside the client's room, usually in the clean utility room.		
7. Use clean basin and scoop or spoon to collect ice.		
8. Fill ice cap or ice bag 1/2 to 2/3 full.		
9. Expel all air.		
10. Dry outside of bag or cap. If moisture is left on the bag, it may penetrate and cause injury.		
11. Apply cover (fitted wrapper or towel pinned around equipment).		
12. Apply against indicated area.		
13. Check the client's skin for signs of complications after the first five minutes; then, continue checking every 30 minutes until treatment is discontinued.		
14. Remove cap or bag when time has elapsed.		
15. Discontinue application at 2-hour intervals or per physician's order.		

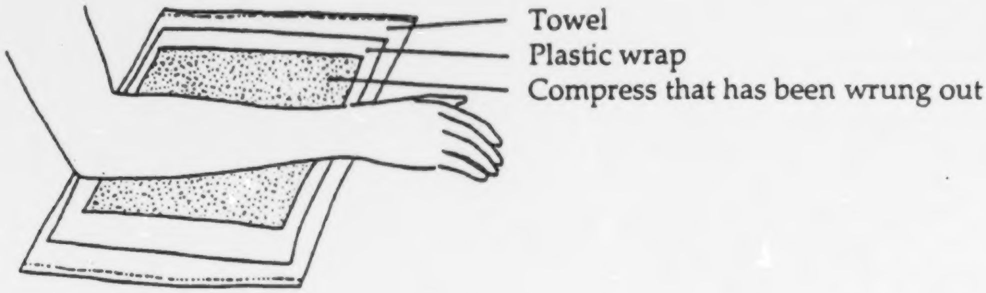
16.	Remove, clean, and store equipment. a. Dry exterior.		
	b. Hang upside-down with cap open.		
	c. Store appliance inflated and closed in a cool place after drying.		
17.	Wash your hands.		
18.	Make client comfortable; place call signal within reach.		
19.	Record observations and report anything unusual to the charge nurse.		

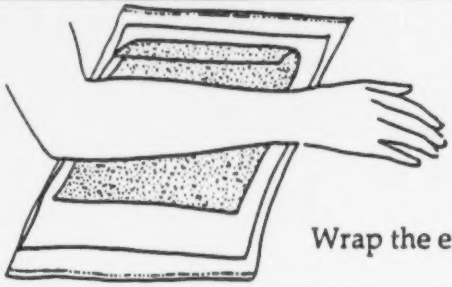
The student has satisfactorily completed the procedure "APPLY AN ICE BAG/ICE CAP" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

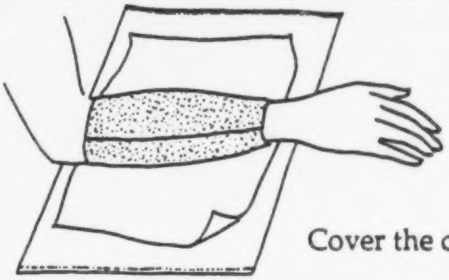
Date

APPLYING A WARM, MOIST COMPRESS


Towel
Plastic wrap
Compress that has been wrung out



Wrap the extremity with the compress.

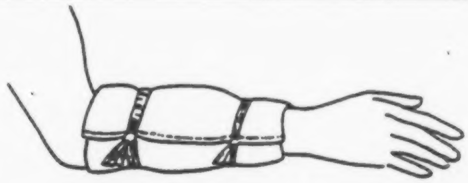


Cover the compress with the plastic wrap.

Check the skin under the heat application for:

- Too much redness
- Discoloration of the skin
- If you think the client is being burned, discontinue treatment

Report this to the charge nurse immediately



Cover the plastic wrap with a towel and secure in place.

LESSON PLAN: 29

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

SCOPE OF UNIT:

The structure and function of the skin and its appendages will be presented in this unit. Medical terminology associated with the skin is included. This unit includes the following care of the client: complete and partial bed bath, tub and shower bath, perineal care, hair care, shaving the client, nail care, skin care, dressing and undressing, warm and cold applications, and decubitus care.

INFORMATION TOPIC: VI-29 AND DEMONSTRATION: VI-29

PREVENTING AND CARING FOR DECUBITUS ULCERS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Describe the main cause of decubitus ulcers.
2. List four pressure areas.
3. Identify three clients prone to formation of decubitus ulcers.
4. List three early signs of a decubitus ulcer.
5. Describe ways the health care assistant can help prevent decubitus ulcers.
6. List observations that should be made about a decubitus ulcer.

Demonstration

7. Give decubitus care according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Pressure Areas
2. Concept Media: "Pressure," Parts 1 and 2
3. Decubitus Ulcers, video (TF #185), available from the Missouri Division of Aging Film Library, 40 min.

4. Television and VCR
5. Lotion
6. Heel and elbow pads
7. Sheepskin
8. Air or water mattress

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 29 (Student Reference page 443) prior to class and be prepared to discuss the information presented and return the demonstration on giving decubitus care.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 52.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 32, Section 10.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6, Sections 1 and 2.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 8.

INTRODUCTION:

A decubitus ulcer is sometimes referred to as a pressure sore or bedsore. It is one of the worst things that can happen to a client. The health care assistant must remember that most decubitus ulcers can be prevented with good nursing care.

Keep in mind that as the health care assistant you can play a major role in the prevention of decubitus ulcers. The health care assistant will not be responsible for changing the dressing over a decubitus but may be asked to help the charge nurse during the procedure.

Any intense pressure can cause death of tissue after only 90 minutes, but it usually takes six to eight hours to occur. Once a decubitus ulcer develops, it is very difficult to heal and is very painful to the client.

LESSON PLAN: 29

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

OUTLINE:

I. Decubitus Ulcers (also called bedsores or pressure sores)

  A. A decubitus ulcer is an inflammation, sore, or lesion that develops over areas where the skin and tissue underneath are injured due to a lack of blood flow.

  B. This lack of circulation usually happens because of continuous pressure on the skin over a bony prominence resulting from the way or length of time a client is positioned.

  C. Pressure is the main cause; other things such as heat, moisture, and irritating substances, such as crumbs, can hasten the development of sores. (II-1)

II. Pressure Areas (HO 1) (II-2)

  A. Back of ear

  B. Back of head

  C. Shoulder blade

  D. Backbone

  E. Elbow

  F. Crest of pelvis

  G. Hipbone

  H. Coccyx region

  I. Buttocks

  J. Knee cap

  K. Outside of ankle

  L. Inside of ankle

  M. Heel

III. Clients Prone to Forming Decubitus Ulcers (II-3)

  A. Elderly clients - due to sluggish circulation, poor nutrition, and lack of exercise/mobility

  B. Paralyzed clients - because of sensory deficit and lack of mobility

  C. Thin and malnourished clients - bony prominence is closer to skin surface

  D. Obese clients - skin in contact with skin can break down; example: underneath the breasts, between legs, and abdominal folds

  E. Incontinent clients - constant dampness irritates the skin

IV. Stages of Decubitus Ulcers

  A. Stage I - This stage is reversible if effort is made to reduce or remove the pressure. It must be documented. Early signs include: (II-4)

    1. Redness and tenderness of the area (but no break in skin) which does not go away with gentle massage of surrounding tissue. In dark-skinned people, the area may only appear drier.

    2. Complaints of a burning sensation

    3. Coldness of the area, bluish-grey color

    4. Presence of edema

  B. Stage II - This stage must be documented.

    1. Skin becomes bluish, mottled, or dusky color.

    2. Top layer of skin is broken or blistered.

    3. Drainage may be present.

  C. Stage III - This stage must be documented.

    1. Breakdown of deep layers of the skin; open sore.

  D. Stage IV - This stage must be documented.

    1. Breakdown extends down to muscle and/or bone.

    2. Drainage is present.

    3. Black dead (necrotic) tissue may be seen in Stages III and IV.

V. Prevention of Decubitus Ulcers

A. Determine which clients are prone to developing sores and check their skin condition frequently.

B. Prevent pressure.

1. Change the client's position frequently, at least every two hours. Encourage clients sitting in a chair or wheelchair to raise themselves every 10 minutes. **(II-5)**

2. Turning should be scheduled for helpless client. Use a turning sheet.

3. Use antipressure devices.

a. Alternating air pressure - cover with only one sheet and draw sheet to avoid additional layers of material between client and mattress

b. Air mattress - keeps pressure off half the body at a time; do not use pins or any sharp objects near mattress

c. Sheepskin - keeps skin dry with air circulating through "wool"; spreads pressure evenly

d. Pillows - provide support

e. Overbed cradle - keeps weight of top linen off client

f. Waterbed - distributes pressure evenly

g. Heel and elbow protectors - decreases friction and rubbing against bed sheets

h. Foot elevator - reduces pressure on heels

i. Encourage clients to drink fluids - offer fluids every time you reposition them.

j. Immediately wash feces or urine off of the skin.

C. Promote good circulation

1. Use gentle massage around bony prominences and reddened areas. Use lotion and protect the skin from scratching, rubbing, or trauma.

2. Passive and active exercises stimulate circulation.

3. Do not elevate the head of the bed too high, no more than 30°.

D. Promote good skin condition

1. Keep skin clean and dry.
2. Keep bed linen dry and free of wrinkles and any other irritating substances.
3. Try to prevent incontinence.
    a. Change wet/soiled linens immediately.
    b. Wash peri area and dry thoroughly.
4. Encourage good nutrition (protein, vitamins, and minerals) and fluid intake.
5. Avoid injury to the skin.

E. Prevent friction on the client's skin by avoiding:
    1. Wrinkles in bed sheet
    2. Pulling a client up in bed/chair and dragging over sheets/pads instead of lifting
    3. Vigorous rubbing/massaging of skin

VI. Observations to Make about Decubitus Ulcers **(II-6)**
    A. Location of the decubitus ulcer - "right inner ankle"
    B. Condition of the skin - "reddened area"
    C. Skin temperature - "warmer to touch than the surrounding skin"
    D. Any treatment you performed - "gently massaged the area around ulcer"

VII. Demonstrate Procedure for Giving Decubitus Care.

VIII. Summary and Conclusion
    A. Decubitus ulcers
    B. Clients prone to forming decubitus ulcers
    C. Indications of decubitus ulcers
    D. Prevention of decubitus ulcers
    E. Observations to make about decubitus ulcers
    F. Review procedures for giving decubitus care.

A decubitus ulcer (pressure sore or bedsore) can be as harmful to the human body as major surgery. It is worth every effort to prevent one. For every minute it takes to cause a decubitus, it takes weeks to heal. Remember the basic prevention and treatment techniques are simply stimulating circulation and avoiding pressure on one area for a long period of time. The next unit is on the digestive system.

LESSON PLAN: 29

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

STEPS OF PROCEDURE FOR GIVING DECUBITUS CARE

1. Wash your hands.

   NOTE: If drainage is present, gloves must be worn.

2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Check turning schedule.
6. Observe reddened area.
7. Wash skin area with soap and water if soiled.
8. Rub skin around reddened area with warmed lotion.
9. Place clean linen on bed if necessary.
10. Tighten linen (must be free from wrinkles).
11. Turn client to side listed on turning schedule.
12. Remove, clean, and store equipment.
13. Wash your hands.
14. Record care given, time given, and side to which client was turned.
15. Record observations and report anything unusual to the charge nurse.

LESSON PLAN: 29
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT VI: THE SKIN AND ITS APPENDAGES

INTERACTION ITEMS:

1. What is the main cause of a decubitus ulcer?
2. Where are the pressure areas of the body located?
3. What type of clients are prone to forming decubitus ulcers?
4. How can the health care assistant detect the development of a decubitus ulcer in the early stage?
5. How can the health care assistant help prevent decubitus ulcers?
6. What observations should the health care assistant report about a decubitus ulcer?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show students antipressure devices.
2. Show audiovisuals.
3. Instructor demonstrates decubitus care procedure.
4. Students practice steps in decubitus care procedure.
5. Have class sit without moving for fifteen minutes, then ask if they can understand how the client who is turned every two hours feels.

ANSWERS TO EVALUATION ITEMS:

1. c
2. d

3. The student may list any four of the following:
   a. Back of ear
   b. Back of head
   c. Shoulder blade
   d. Backbone
   e. Elbow
   f. Crest of pelvis
   g. Hipbone
   h. Coccyx region
   i. Buttocks
   j. Knee cap
   k. Outside of ankle
   l. Inside of ankle
   m. Heel

4. c
5. b
6. a
7. b
8. d

LESSON PLAN: 29

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI: THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS:

1. What is another term for bedsore? (Circle the letter of the best answer.)

   a. Serous membrane
   b. Mucous membrane
   c. Decubiti
   d. Bony prominence

2. What is the main cause of a decubitus ulcer? (Circle the letter of the best answer.)

   a. Dry skin
   b. Excess activity
   c. Medications
   d. Pressure

3. List four pressure areas.

   a.

   b.

   c.

   d.

4. Which one of the following individuals is more prone to forming a decubitus ulcer? (Circle the letter of the best answer.)

   a. Independently ambulatory client
   b. Well-nourished client
   c. Paralyzed, incontinent client
   d. Ambulatory, continent client

5. Which of the following is a stage 1 or early sign of a decubitus ulcer? (Circle the letter of the best answer.)

   a. Drainage is present
   b. Redness and tenderness of the area
   c. Bluish discoloration of the area
   d. Blistered, broken skin

6. Which of the following helps prevent decubitus ulcers? (Circle the letter of the best answer.)

   a. Change the client's position at least every two hours.
   b. Massage vigorously over bony prominences and reddened areas.
   c. Keep the head of the bed elevated as high as it will raise.
   d. Limit fluid intake to prevent incontinence.

7. Which one of the following is NOT a necessary measure to prevent decubitus ulcers? (Circle the letter of the best answer.)

   a. Promote good circulation
   b. Promote friction on the client's skin
   c. Prevent pressure
   d. Promote good skin condition

8. Which of the following are observations that the health care assistant should note and report when caring for a client who is prone to or has a decubitus ulcer? (Circle the letter of the best answer.)

   a. Skin condition and color
   b. Skin temperature
   c. Location of the decubitus ulcer
   d. All of the above

LESSON PLAN: 29

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VI : THE SKIN AND ITS APPENDAGES

EVALUATION ITEMS: NAME OF STUDENT:______________

GIVE DECUBITUS CARE

EQUIPMENT:

1. Lotion
2. Heel and elbow pads
3. Sheepskin
4. Air or water mattress

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. NOTE: If drainage is present, gloves must be worn.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Check turning schedule.		
6. Observe reddened area.		
7. Wash skin area with soap and water if soiled.		
8. Rub skin around reddened area with warmed lotion.		
9. Place clean linen on bed if necessary.		
10. Tighten linen (must be free from wrinkles).		
11. Turn client to side listed on turning schedule.		
12. Remove, clean, and store equipment.		
13. Wash your hands.		
14. Record care given, time given, and side to which client was turned.		
15. Record observations and report anything unusual to the charge nurse.		

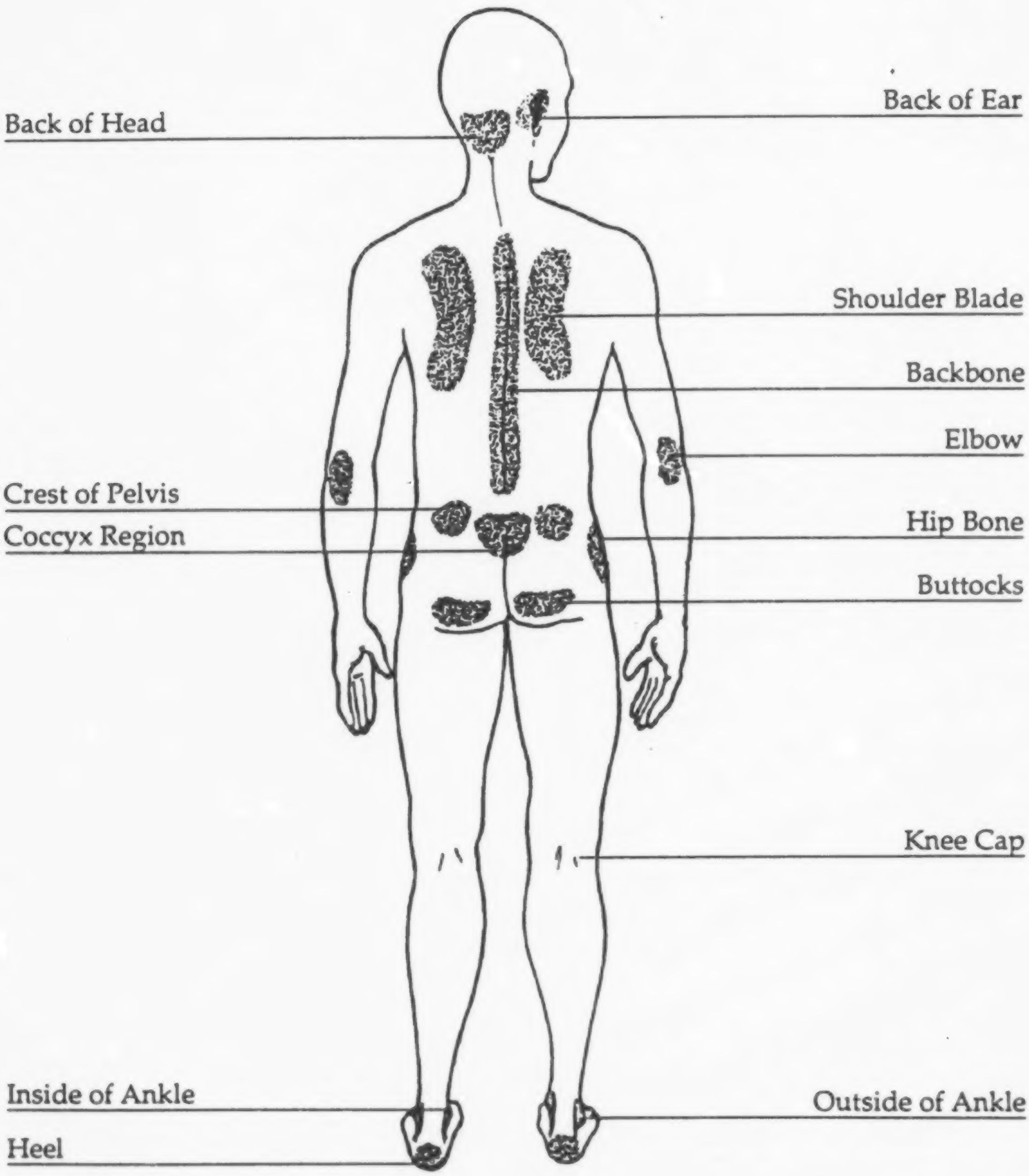
The student has satisfactorily completed the procedure "GIVE DECUBITUS CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

HO 1

PRESSURE AREAS


Back of Head
Back of Ear
Shoulder Blade
Backbone
Elbow
Crest of Pelvis
Coccyx Region
Hip Bone
Buttocks
Knee Cap
Inside of Ankle
Heel
Outside of Ankle

LESSON PLAN: 30

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-30 OR DEMONSTRATION:

DIGESTIVE SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with their correct definitions.
2. Describe the digestive system.
3. Describe the structure and function of the alimentary canal.
4. Label the true organs of the digestive system.
5. Describe the accessory organs of digestion and their functions.
6. Label the accessory organs of the digestive system.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Digestive System
2. HO 2: True Digestive Organs
3. HO 3: Junction of Stomach and Intestine
4. HO 4: Accessory Digestive Organs
5. HO 5: Molar

6. HO 6: Incisor

7. HO 7: Primary/Permanent Teeth

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 30 (Student Reference page 455) prior to class and be prepared to discuss the information presented.

REFERENCES:

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Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

Digestion is the process of breaking complex foods into soluble, absorbable materials. The body then absorbs or stores the needed nutrients and eliminates the waste products.

LESSON PLAN: 30

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

  A. Mastication - process of chewing

  B. Absorption - passing of a substance into body fluids and tissues

  C. Peristalsis - progressive wave of contraction in a tubular structure provided with longitudinal and transverse muscular fibers, as in the esophagus, stomach, and small and large intestines

  D. Mucosa - mucous membrane

  E. Sphincter - circular muscle, such as the anus

  F. Enzyme - organic catalyst that initiates and accelerates a chemical reaction

  G. Defecation - elimination of waste material from the rectum

  H. Mucus - the slippery secretions of the mucous membrane, composed of mucin, various salts, and body cells

  I. Secretion - the expulsion of material which has been chemically modified by a cell to serve a purpose in another body process

  J. Digestion - the process of changing complex solid foods into simpler soluble forms which can be absorbed by the body cells

  K. Alimentary canal - also known as the digestive tract and gastrointestinal tract

  L. Ailment - latin term meaning food

  M. Gastero - greek term meaning food

  N. Enteron - means intestine

  O. Logy - means study of

  P. Gastroenterology - study of the stomach and intestines and their diseases

  Q. Itis - means inflammation of a part

R. Gastritis - inflammation of the stomach

S. Enteritis - inflammation of the intestine

T. Deglutition - swallowing

U. Cholecystectomy - excision or removal of the gallbladder

V. Cholecystitis - inflammation of the gallbladder

W. Dipsosis - a condition producing thirst

X. Hepatic - of or pertaining to the liver

Y. Hepatitis - inflammation of the liver

Z. Hepatitis - inflammation of the liver

AA. Ileitis - inflammation of the ileum

AB. Polydipsia - excessive thirst

AC. Proctologist - specialist in the diagnosis and treatment of rectal disorders

AD. Proctoscopy - examination of the rectum by the use of a proctoscope

II. Digestive System (HO 1)

A. Description

1. The organs of the digestive system form an irregular-shaped tube, that is open at both ends.

2. This tube is also called the gastrointestinal tract or alimentary canal or GI tract.

3. Organs of the alimentary canal are found in the head, thorax, abdomen, and pelvis. (II-2)

4. It consists of the mouth, pharynx, esophagus, stomach, small and large intestines, and anus.

5. It is 20 to 30 feet long.

6. It is a tube within a tube. The body being one tube and the alimentary canal being the other tube. Food which we eat is in the alimentary canal, not in the body. Think of a car tire with an inner tube.

7. Accessary organs are the teeth, tongue, salivary glands, pancreas, liver, and gallbladder.

B. The four layers of the walls of the alimentary canal

  1. Mucosa - the innermost lining; is made up of epithelial cells

  2. Submucosa - consists of connective tissue with fibers, blood vessels, and nerve endings

  3. Circular muscle

  4. Longitudinal muscle

III. General Function of the Digestive System

  A. Transports food

  B. Physical breakdown of food - mastication (chewing)

  C. Chemical breakdown of food - food mixes with mucus that is produced by the lining of the gastrointestinal tract

  D. Absorption

  E. Elimination

IV. True Organs of the Digestive System

  A. Oral or buccal cavity - mouth (HO 2)

    1. Description - consists of a roof, a floor, and uvula

    2. Roof includes the hard and soft palates

      a. Hard palate contains bones: palatine bones and parts of the maxillary bones.

      b. Soft palate consists of muscle.

      c. It separates the mouth from the part of throat behind the nose (nasopharynx).

      d. The archway of the soft palate opens into the oropharynx which is the part of the throat behind the mouth.

    3. Uvula

      a. Hangs down from the center of the soft palate (II-3)

      b. Prevents food from entering the nasal cavity when swallowing

    4. Floor of the mouth - tongue and its muscles

a. Attached to the floor of the mouth

b. Function

   (1) Helps in chewing

   (2) Helps in swallowing

c. Can be moved in many directions because it is made from skeletal muscle

d. Attached to the hyoid, mandible, and two temporal bones

e. Papillae - knob-like elevations

   (1) Papillae contain the taste buds.

   (2) We can taste salt, bitter, sweet, and sour.

   (3) They are also sensitive to cold, heat, and pressure.

5. Function

   a. Taste

   b. Speech

   c. Chewing

   d. Swallowing

B. Pharynx

1. Description

   a. A tube-like structure made of muscle

   b. Lined with mucous membrane

2. Located behind the nasal cavities and the mouth

3. Function

   a. The pharynx is part of the digestive and respiratory systems. **(II-4)**

   b. Air passes through the pharynx on its way to the lungs.

   c. Food passes through it on its way to the stomach.

C. Esophagus

1. Description

   a. Sometimes thought of as the food pipe

   b. Muscular, mucous lined tube that connects the pharynx with the stomach (II-5)

   c. Approximately 10 inches long

2. Function

   a. Passageway for food and water

   b. Produces mucous

D. Stomach (HO 3)

1. Description

   a. Located in the upper part of the abdominal cavity, just to the left of and below the diaphragm (II-6)

   b. It is an elastic bag whose shape and position are determined by:

      (1) Amount of food eaten

      (2) Stage of digestion

      (3) Position of the body

      (4) Pressure exerted on it from the intestines

2. Structure

   a. Divided into three portions

      (1) Fundus - upper portion

      (2) Body or greater curvature - middle section

      (3) Pylorus - lower portion

   b. Cardiac sphincter - circular layer of muscle

      (1) It is called the cardiac sphincter because of its proximity to the heart.

(2) It controls the passage of food into the stomach.

c. Pyloric sphincter valve - regulates the passage of food into the first part of the small intestine (duodenum)

d. Four layers of the stomach wall

(1) Mucous coat

(a) Innermost layer

(b) Made up of small gastric glands

(2) Submucosa coat

(a) Made up of loose connective tissue

(b) Connects the mucous coat with the muscular coat

(3) Muscular coat

(a) Made up of three layers of smooth muscle

(b) Helps the stomach to undergo peristalsis: pushes the food into the small intestines

(4) Serosa - thick outer layer of the stomach

(a) Continuous with the entire inner abdominal cavity (peritoneum)

(b) Serosa and peritoneum meet at certain points, surrounding the organs around the stomach and holding them in place.

(c) Greater omentum - hangs in front of the intestines and contains a large amount of fat

3. Function

a. Digestion

b. Reservoir

c. Absorption

d. Destruction of bacteria

e. Secretion of gastric juices (hydrochloric acid)

E. Small intestine

1. Description

   a. Coiled portion of the alimentary canal

   b. Twenty (20) to twenty five (25) feet long

   c. One (1) inch in diameter

   d. Contains thousands of microscopic glands (intestinal glands) that secrete the intestinal digestive juices

   e. It is a smooth muscle that produces peristalsis.

   f. The lining of the small intestine is covered with millions of small projections called villi. This is where the digested part of food passes through the villi into the blood stream and then to the body cells.

2. Structure in order of location (II-7)

   a. Duodenum - first portion

   b. Jejunum - middle portion

   c. Ileum - last portion

3. Function

   a. Storage

   b. Digestion

      (1) Digestion breaks up fat into small droplets so the digestive juices can act upon it. This is done with bile from the liver which is poured into the duodenum.

      (2) Pancreatic juice, which is poured into the duodenum from the pancreas, continue the digestion of protein which started in the stomach. It also acts on starch and digests fat.

      (3) Enzymes of the intestinal juices complete the digestion of carbohydrates and proteins.

   c. Absorption - the combination of the actions of bile, pancreatic juice, and intestinal juice complete the process of breaking down food for absorption into the blood stream.

F. Large intestine

1. Description

    a. Often referred to as the colon

    b. Approximately 5 feet long and 2 inches in diameter

    c. It starts at the lower right hand corner of the abdominal cavity and goes up, across, and down.

2. Structure

    a. Cecum

        (1) The cecum is a blind pouch located slightly below the ileocecal (or colic) valve, in the lower right portion of the abdomen.

        (2) The ileocecal valve is the opening through which the ileum empties into the wall of the colon.

    b. Appendix - a finger-like projection that protrudes into the abdominal cavity

    c. Colon - consists of three parts: ascending, transverse, and descending **(II-8)**

        (1) Ascending colon - located upward, along the right side of the abdominal cavity, to the underside of the liver

        (2) Transverse colon - located across the abdominal cavity

        (3) Descending colon - located down the left side of the abdominal cavity

            (a) At the point where it enters the pelvis, there is an S-shaped bend which is called the sigmoid colon.

            (b) Sigmoid colon extends approximately 7 to 8 inches as the rectum.

            (c) The rectum opens into the anus.

            (d) Two sphincter muscles stay contracted to keep the anus closed except when one is having a bowel movement.

3. Function

    a. Water absorption

        (1) It draws water from undigested food that passes through the colon. **(II-9)**

(2) A large amount of this water is absorbed back into the blood stream.

b. Bacterial action

(1) Shortly after birth, bacteria enter our bodies through the food we eat.

(2) Some of the bacteria are destroyed by the acid found in the colon. A large number continue into the colon where they form what is called flora.

(3) The flora acts upon undigested food. Some flora are excreted through the colon.

(4) The bacterial action also helps in the formation of a moderate amount of B-complex and vitamin K which our bodies need for blood clotting.

c. Reabsorbs bile salts

d. Fecal formation

e. Defecation

(1) Approximately every 12 hours, fecal material moves into the lower colon and rectum.

(2) Peristalsis begins, which causes nerve endings in the rectum to be stimulated.

(3) The nerve impulses are transmitted first to the spinal cord, then to the colon, rectum, and internal small sphincter muscle.

f. A large amount of food absorption takes place in the large intestine.

V. Accessory Organs of Digestion (HO 4)

A. Teeth

1. Description (HOs 5, 6, & 7)

a. The gums support and protect the teeth.

b. The teeth chew food and break it down into small morsels which enables the digestive enzymes to digest the food.

c. We get two sets of teeth, the deciduous and the permanent teeth.

2. Structure - three main parts: crown, neck, and root

   a. Crown

      (1) Exposed visible part in your mouth

      (2) Covered with enamel for grinding during chewing

      (3) Also covered by two other dental tissues: dentin and cementum

         (a) Dentin makes up the greatest part of the tooth shell. It is covered by enamel in the crown area. It contains a pulp cavity which consists of connective tissue, blood and lymphatic vessels, and sensory nerves.

         (b) Cementum covers the tooth shell in the neck and root areas.

   b. Neck - narrow portion that is surrounded by gum tissue and that joins the crown of the tooth to the root

   c. Root - fits into the socket of either the upper or lower jaw

   d. Types **(II-10)**

      (1) Deciduous or primary (baby teeth)

         (a) We begin to get these teeth at approximately six (6) months of age and continue to about two (2) years of age.

         (b) Twenty (20) are cut - 10 uppers and 10 lowers

         (c) 4 incisors, 2 canines, and 4 molars

         (d) They last to about the age of six (6).

      (2) Permanent

         (a) 32 permanent teeth push out the deciduous teeth.

         (b) 8 incisors - cut food

         (c) 4 canines - shred food

         (d) 8 premolars or first molars - crush and grind food

         (e) 12 molars (four wisdom teeth) - crush and grind food

B. Salivary glands

1. Description

a. Located outside the alimentary tract

b. Convey their secretions by way of ducts into the alimentary tract

c. Produce a watery secretion called saliva

2. Location (II-11)

a. Parotid salivary gland - on both sides of the face, in front of and below the ears

b. Submaxillary gland - located near the angle of the lower jaw; sometimes called the submandibular gland

c. Sublingual gland - found under the sides of the tongue

3. Function

a. Saliva softens and lubricates food making it easier to chew and swallow. It also dissolves part of the food so it can be tasted.

b. Saliva contains an enzyme ptyalin which digests starches to dextrose. This process is continued in the stomach.

c. Saliva aids in speech by keeping the mouth flexible and moist.

C. Liver

1. Description - classified as an exocrine gland because its cells secrete bile into ducts

2. Location

a. On the upper right side of the abdominal cavity just below the diaphragm; extends partway over to the left side.

b. It contains four lobes. (II-12)

3. Function

a. Manufactures bile and passes it to the gallbladder where it is stored and released for the digestion of fat when needed

b. Produces and stores glycogen from unused digested sugars

        c. Removes certain waste products from the blood stream and changes them into a form that can be excreted by the kidneys

        d. Aids in the metabolism of all kinds of foods

        e. Produces blood protein or plasma proteins which are essential for blood clotting

        f. Helps maintain blood volume

        g. Detoxifies various poisonous substances and certain drugs

    D. Gallbladder (II-13)

        1. Located on the underneath surface of the liver

        2. Function - stores and releases bile to emulsify fats

VI. Summary and Conclusion

    A. Terms and definitions

    B. Digestive system

    C. General functions of the digestive system

    D. True organs of the digestive system

    E. Accessory organs of digestion

In the next lesson, you will learn what happens to the food you eat and why it is important to have a daily diet which includes the essential nutrients.

LESSON PLAN: 30

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms found in this lesson?
2. What organs make up the alimentary canal?
3. Where is the uvula located?
4. What is the function of the pharynx?
5. Where is the esophagus located?
6. Where is the stomach located?
7. What are the names of the three portions of the small intestine?
8. Where are the ascending colon, transverse colon, and descending colon located?
9. Where does the majority of food absorption take place?
10. What is the name of the two types of teeth we have during our lifetime?
11. Where are the parotid, submaxillary, and sublingual salivary glands located?
12. How many lobes does the liver have?
13. Where is the gallbladder located?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Locate on an anatomical model the true digestive organs, then the accessory organs.
2. Trace a bite of food from ingestion to defecation. Explain what happens to food along its way through the digestive system.
3. Invite a dental hygienist, dental assistant, or dentist to speak on care of teeth.

ANSWERS TO EVALUATION ITEMS:

1. b
2. f

3. g
4. a
5. d
6. e
7. d
8. b
9. c
10. a
11. d
12. b
13. c
14. b
15. Deciduous or primary and permanent
16. d
17. lobes
18. liver

19. a. mouth
    b. pharynx
    c. esophagus
    d. stomach
    e. large intestine
    f. small intestine

20. a. teeth
    b. salivary glands
    c. liver
    d. gallbladder
    e. pancreas

LESSON PLAN: 30

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I

____ 1. Alimentary canal

____ 2. Mastication

____ 3. Defecation

____ 4. Digestion

____ 5. Absorption

____ 6. Secretion

Column II

a. The process of changing complex solid foods into simpler soluble forms which can be absorbed by the body cells

b. Also known as the digestive tract and gastrointestinal tract

c. Organic catalyst that initiates and accelerates a chemical reaction

d. Passing of a substance into body fluids and tissues

e. The expulsion of material which has been chemically modified by a cell to serve a purpose in another body process

f. Process of chewing

g. Elimination of waste material from the rectum

7. Which one of the following statements best describes the digestive system? (Circle the letter of the best answer.)

   a. The organs of the digestive system form a straight tube that is open at one end.
   b. Food which we eat enters the body through the mouth.
   c. The submucosa is the innermost lining of the alimentary canal.
   d. The alimentary canal consists of the mouth, pharynx, esophagus, stomach, small and large intestines, and the anus.

8. What is the structure of the mouth which hangs down from the center of the soft palate called? (Circle the letter of the best answer.)

   a. Roof
   b. Uvula
   c. Floor
   d. Side wall

9. A structure of the digestive system which also functions as part of the respiratory system is called the: (Circle the letter of the best answer.)

   a. Larynx.
   b. Esophagus.
   c. Pharynx.
   d. Tongue.

10. The esophagus connects the: (Circle the letter of the best answer.)

   a. Pharynx with the stomach.
   b. Uvula with the pharynx.
   c. Stomach with the ileum.
   d. Jejunum with the appendix.

11. Where is the stomach located? (Circle the letter of the best answer.)

   a. Upward, along the right side of the abdominal cavity
   b. Across the abdominal cavity
   c. Down the left side of the abdominal cavity
   d. Upper part of the abdominal cavity, to the left, and below the diaphragm

12. Which one of the following is NOT a structure of the small intestine? (Circle the letter of the best answer.)

   a. Duodenum
   b. Sigmoid colon
   c. Ileum
   d. Jejunum

13. Where is the descending colon located? (Circle the letter of the best answer.)

   a. Across the abdominal cavity
   b. Upward, along the right side of the abdominal cavity
   c. Down the left side of the abdominal cavity
   d. At the end of the duodenum and connected to the cecum

14. Most food absorption takes place in the: (Circle the letter of the best answer.)

   a. Stomach.
   b. Small intestine.
   c. Colon.
   d. Large intestine.

15. Two types of teeth which we have during our lifetime are the ____________________ and ____________________.

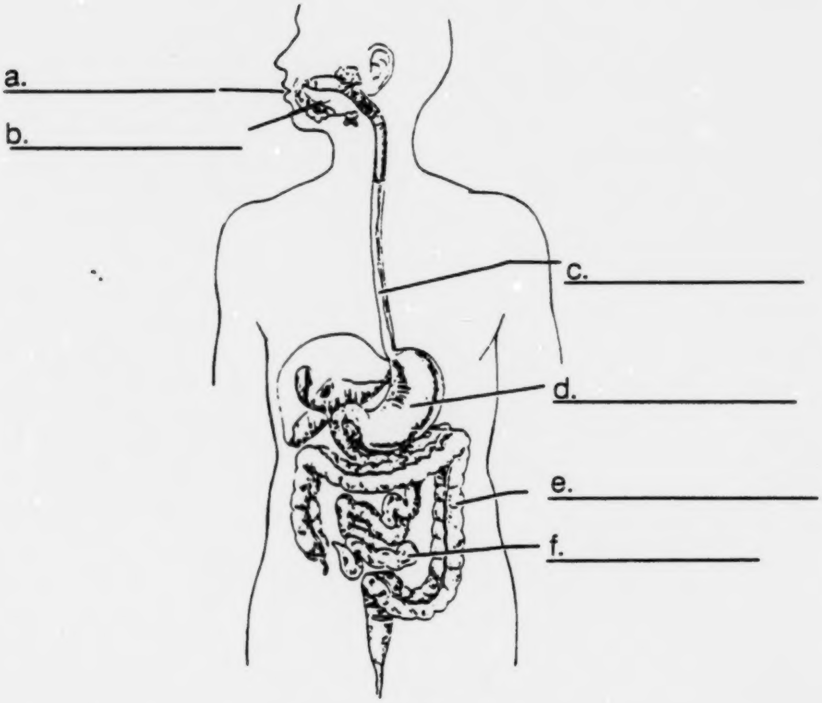
16. Where is the parotid salivary gland located? (Circle the letter of the best answer.)

   a. Inside the alimentary tract
   b. Near the angle of the lower jaw
   c. Under the sides of the tongue
   d. Both sides of the face, in front and below the ears

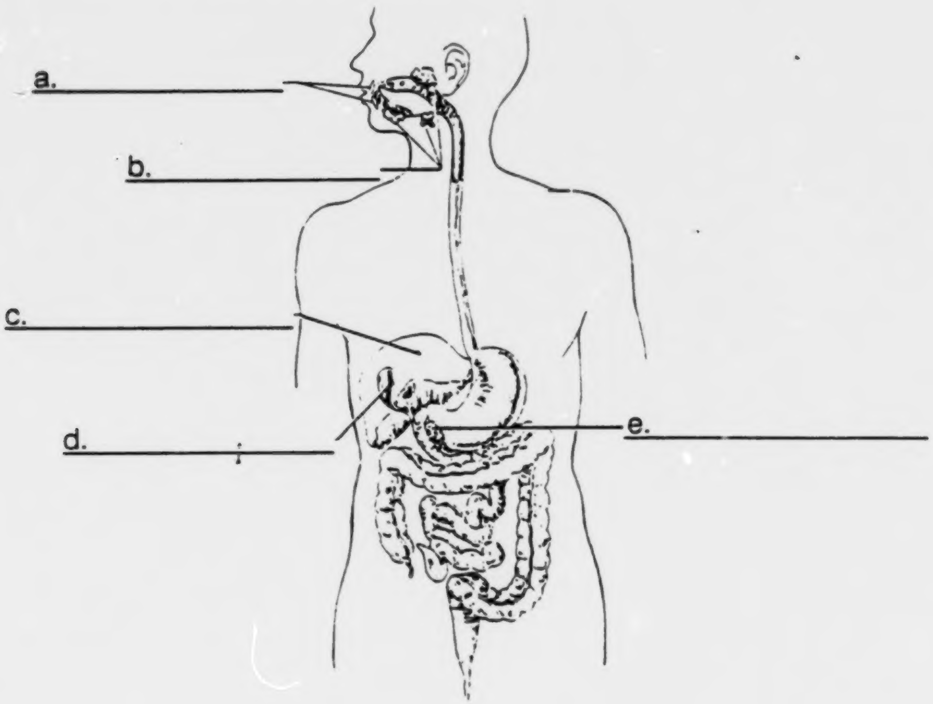
17. The liver contains four ____________________.

18. The gallbladder is located on the underneath surface of the ____________________.

19. Label true parts of the digestive system on the diagram below.



20. Label the accessory organs of the digestive system on the diagram below.



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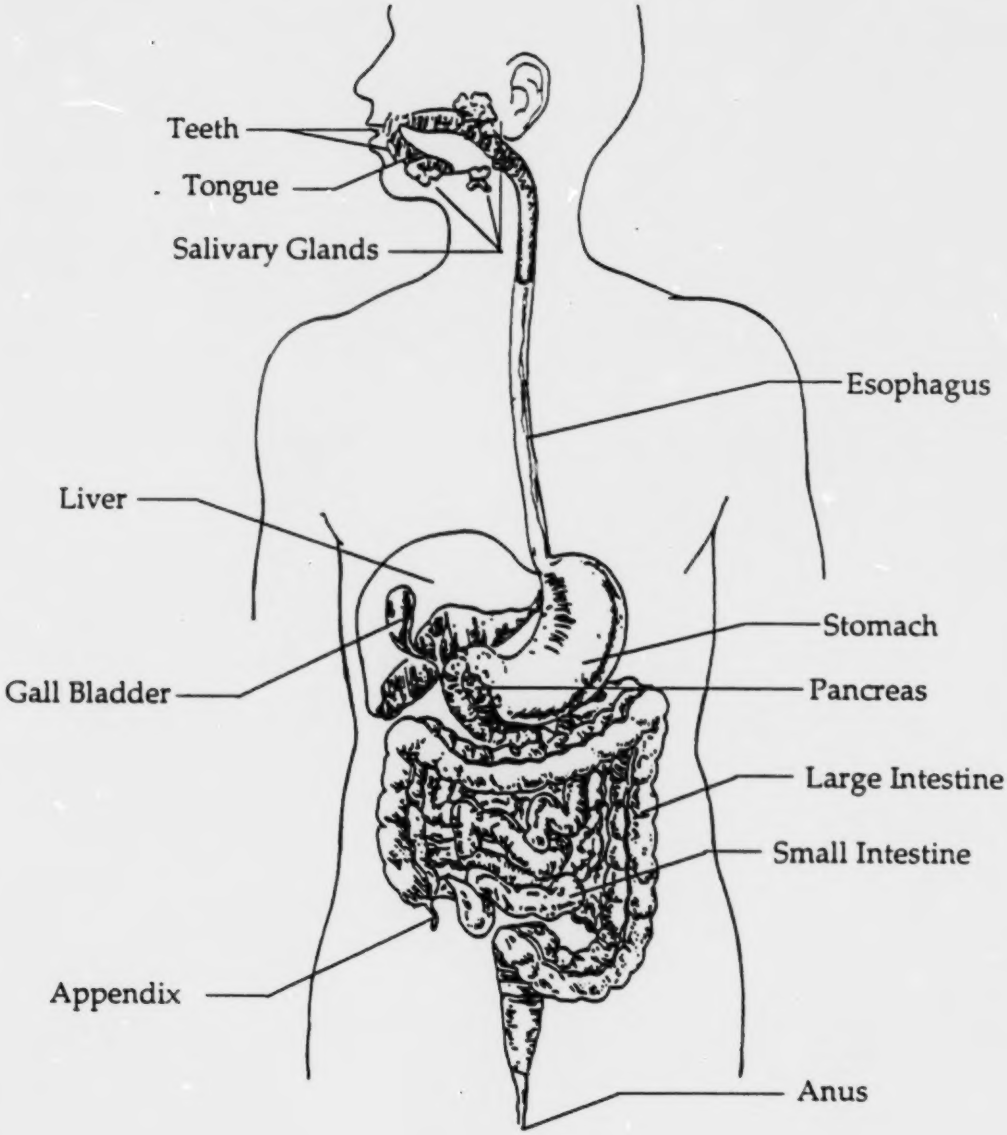
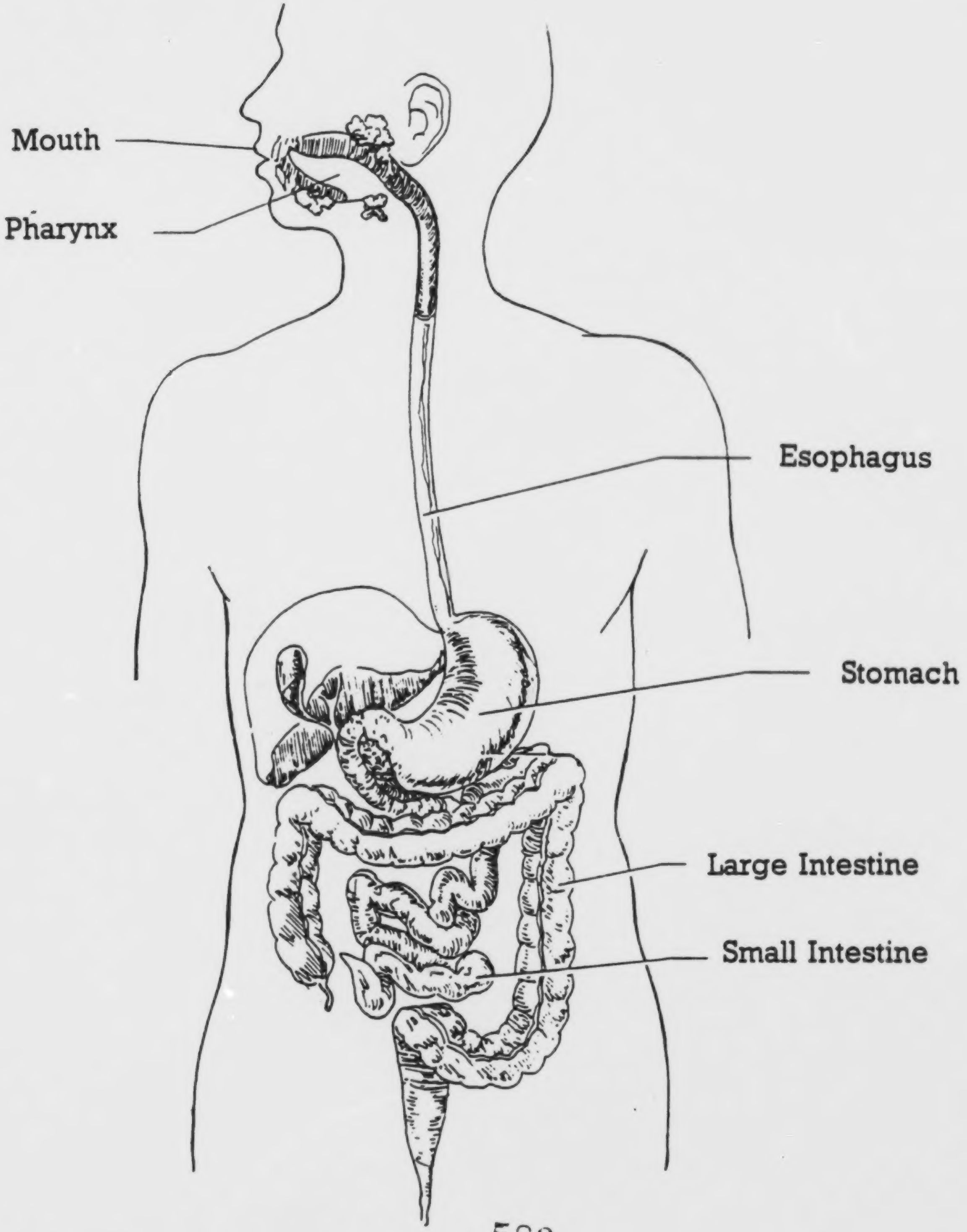
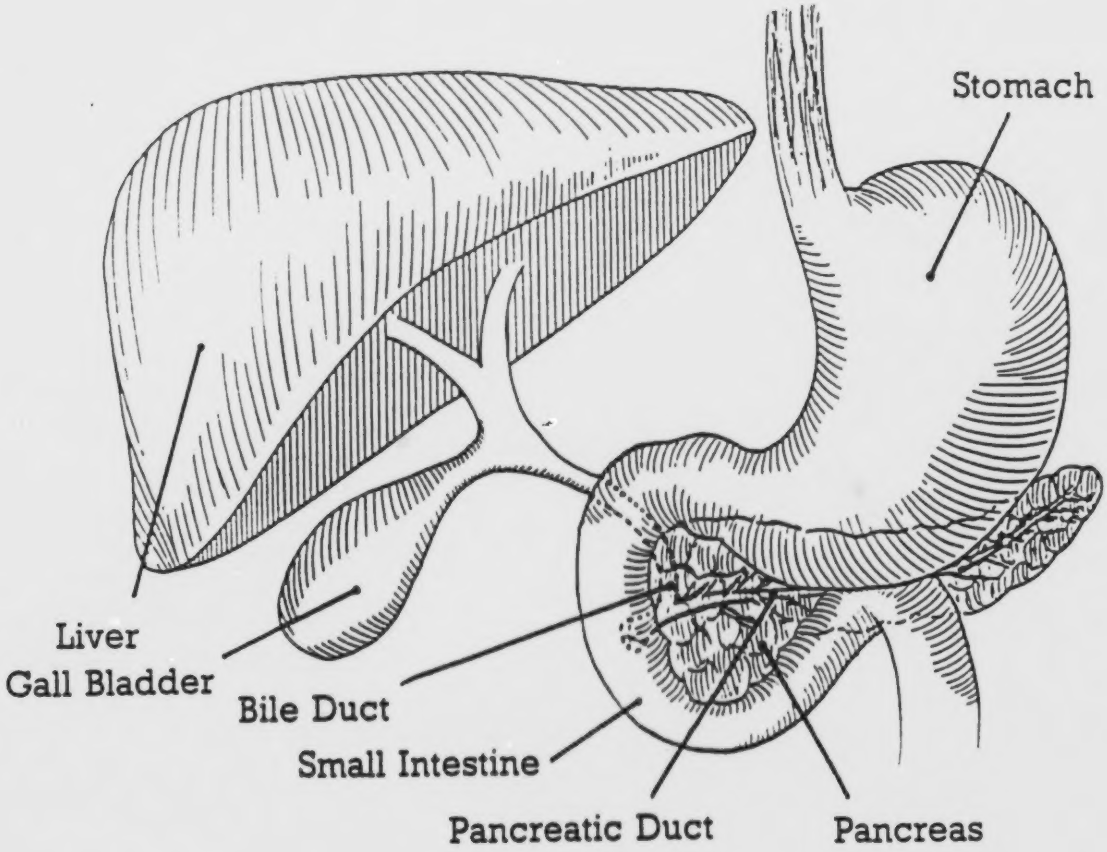
DIGESTIVE SYSTEM


Teeth
Tongue
Salivary Glands
Esophagus
Liver
Stomach
Gall Bladder
Pancreas
Large Intestine
Small Intestine
Appendix
Anus

TRUE DIGESTIVE ORGANS

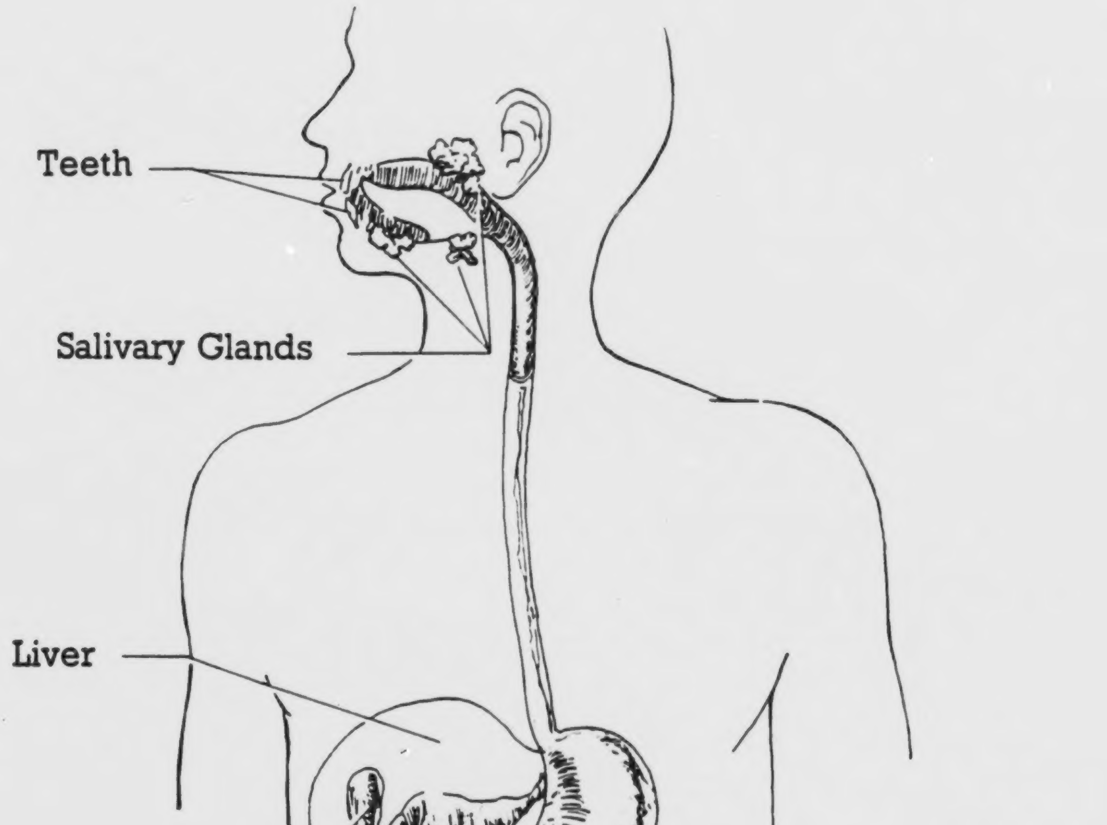

Mouth
Pharynx
Esophagus
Stomach
Large Intestine
Small Intestine

JUNCTION OF STOMACH AND INTESTINE

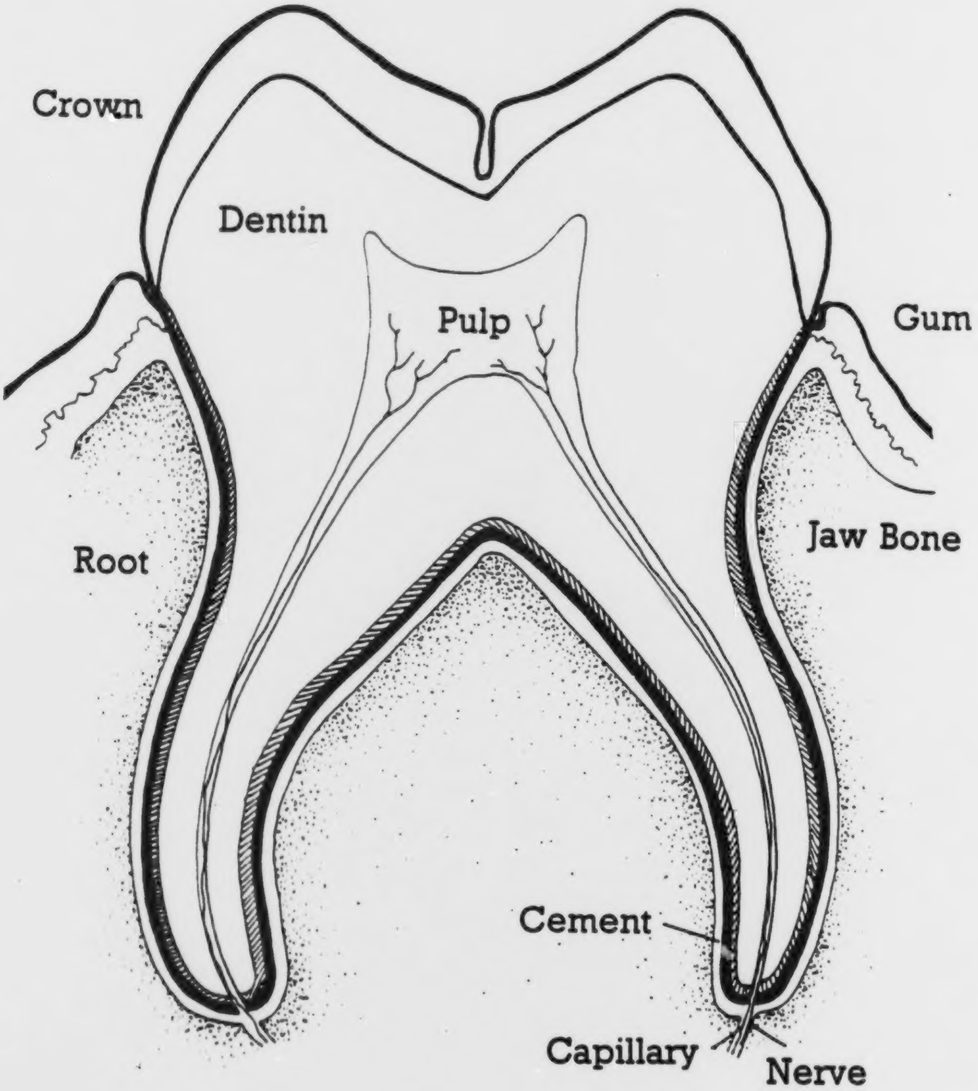

Stomach
Liver
Gall Bladder
Bile Duct
Small Intestine
Pancreatic Duct
Pancreas

590

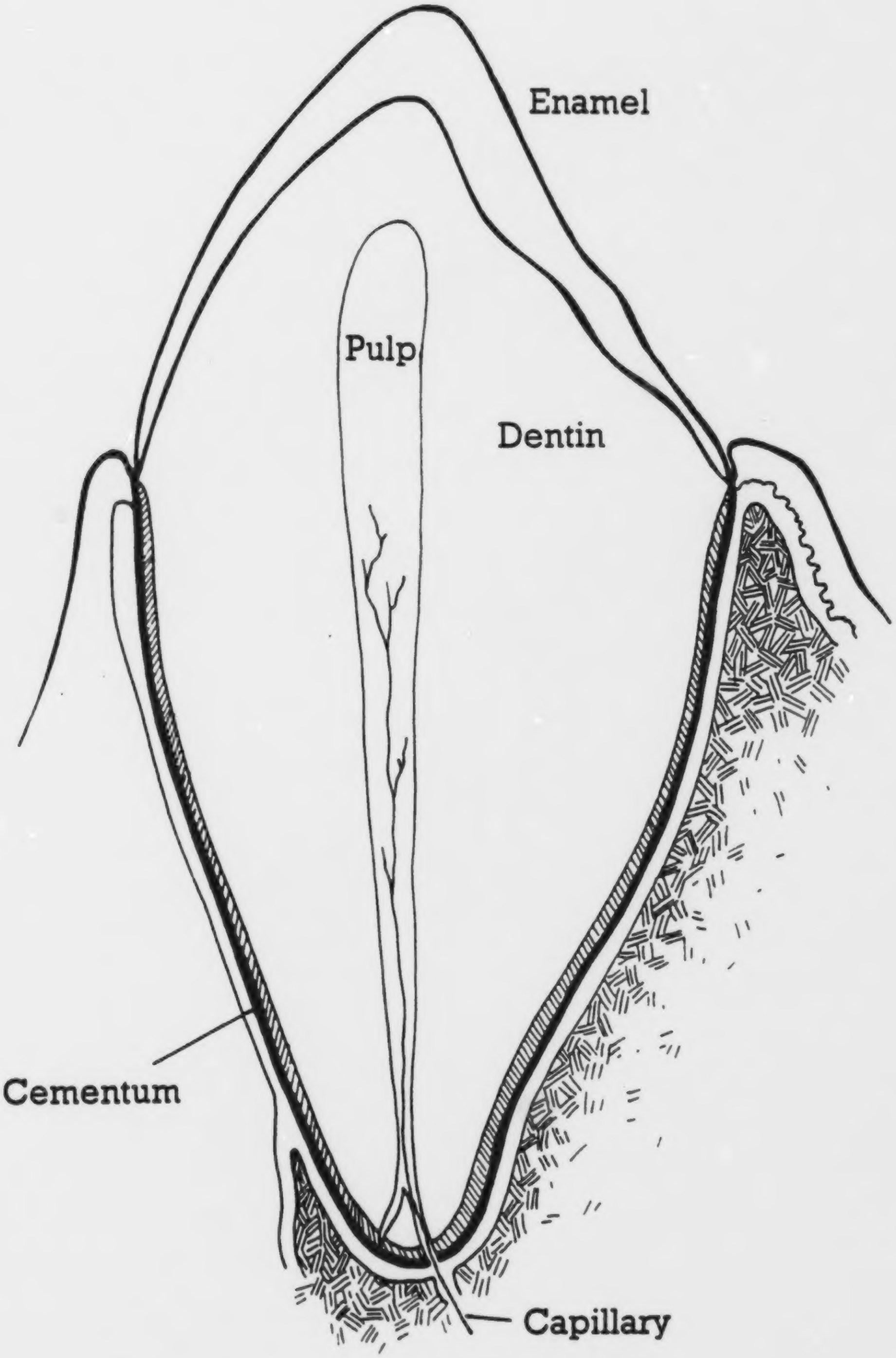
ACCESSORY DIGESTIVE ORGANS


Teeth
Salivary Glands
Liver
Gall Bladder
Pancreas

MOLAR

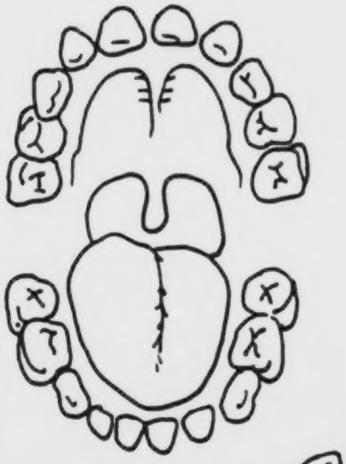

Crown
Dentin
Pulp
Gum
Root
Jaw Bone
Cement
Capillary
Nerve

INCISOR


Enamel
Pulp
Dentin
Cementum
Capillary

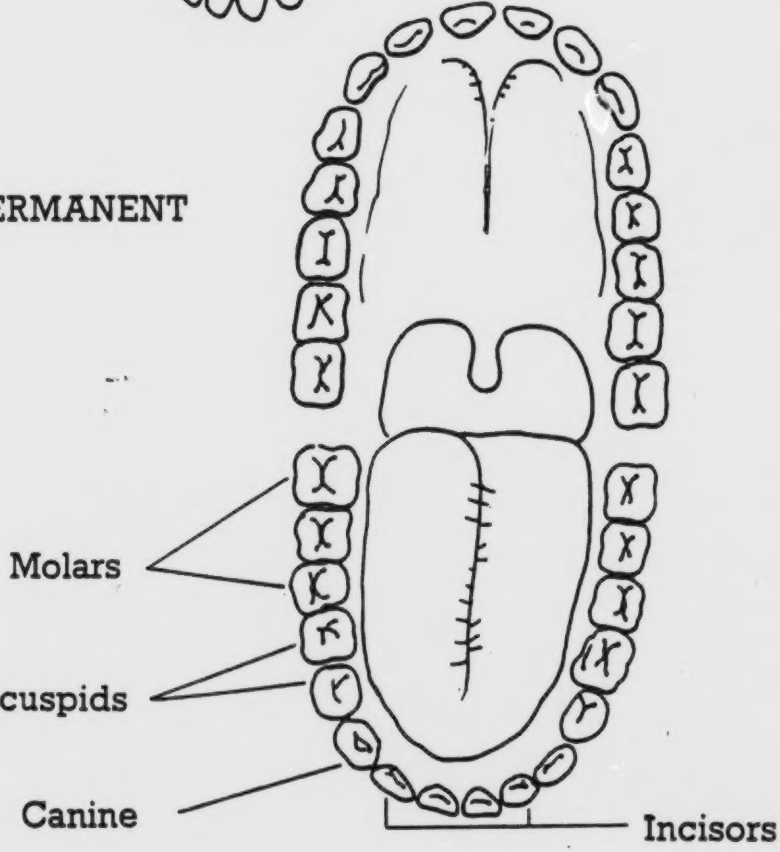
HO 7

PRIMARY/PERMANENT TEETH



PRIMARY OR DECIDUOUS

PERMANENT


Molars
Bicuspids
Canine
Incisors

LESSON PLAN: 31

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-31 OR DEMONSTRATION:

NUTRITION
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Match the five categories of nutrients with their functions.
3. List foods included in each of the food groups.
4. Identify foods from six special diets commonly ordered in health care facilities.
5. Identify two methods of providing a nutritionally complete liquid diet.
6. Discuss the importance of non-nutrients.
7. Discuss the nutritional needs of the elderly.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: General Nutrition
2. HO 2: The Basic Food Groups
3. HO 3: Basic Food Groups

4. Audiovisuals available from the Missouri Division of Aging Film Library

   a. Food Safety is No Mystery, video (TF #96), 34 min.
   b. Cholesterol...A New Outlook, video (TF #137), 11 min.
   c. Eating for Your Health, slide/tape (TF #63), 55 min.
   d. Exchange Lists for Meal Planning, video (TF #88), 60 min.
   e. Nutrition in the Later Years, 16mm film (TF #82), 30 min.
   f. Nutritional Aspects of the AIDS Patient, video (TF #139), 28 min.
   g. Operation of the Flexifol Companion Pump, video (TF #95), 39 min.
   h. The Right Choice, video (TF #182), 22 min.

5. Food, Energy, and You, Food, The Color of Life, and What's Good to Eat available from the Dairy Council

6. Projector

7. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 31 (Student Reference page 479) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 19 and 20.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 16.

Missouri Dietetic Association and Missouri Division of Health. Missouri Diet Manual. 7th ed. 1992.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 9.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 9.

INTRODUCTION:

Food is very important to all of us no matter what our age. The whole process of taking in food and producing energy from it is called nutrition. Nutrition becomes extremely important for the health care client who may have some impairment in his/her digestive process. The elderly person needs the same nutrition as he/she did at an earlier age, but less calories are required. It is important that we understand basic nutrition.

LESSON PLAN: 31
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT VII : THE DIGESTIVE SYSTEM

OUTLINE:

I. Terms and Definitions* (II-1)

  A. Defecation - passing of stool

  B. Digestion - process by which food is broken down, mechanically and chemically, and changed to a form that can be absorbed by the body

  C. Nutrient - food that supplies the body with its necessary elements

  D. Nutrition - the process of taking in food and producing energy from it

  E. Peristalsis - wave-like movements of the digestive tract which move food through

  F. Residue - what remains of something after a part is removed

  G. Roughage - indigestible fiber of fruits, vegetables, and cereal which acts as a stimulus to aid intestinal peristalsis

II. Five Categories of Nutrients (II-2)

  A. Protein

    1. Functions are to build and repair tissue, help build blood, help form antibodies and provide energy.

    2. If excess protein is taken in, the body will change it to fat and store it as fat.

    3. Sources - eggs, meat, fish, poultry, dairy products, nuts, and beans (II-3)

  B. Carbohydrates

    1. Give the body a source of immediate energy

    2. Broken down by digestive process into simple sugars (The most important one is glucose.)

    3. If excess carbohydrates are taken in, the body will convert them to fat.

    4. Sources - breads, cereals, sugar, syrup, fruits, and vegetables (II-4)

C. Fats

1. Main function is to be stored as energy for later use.

2. Sources - butter, cream, salad oil, whole milk, meat, fish, and nuts (II-5)

D. Vitamins

1. Vitamins are important for the proper breakdown and use of nutrients.

2. A well-balanced diet contains sufficient amounts of vitamins.

3. Vitamins may be destroyed by overcooking or exposure to air.

4. Identified by letters such as A, B-complex, C, D, E, and K

5. Sources - vary with each vitamin

E. Minerals

1. Regulate many body processes

2. Examples - calcium, phosphorus, sodium, iron

3. Sources - vary with each mineral

III. Basic Food Groups (HOs 1, 2, & 3) - A balanced diet contains a particular number of food servings from each of the five food groups. The client on a regular diet has no restrictions. (II-6)

A. Meat group

1. Ex.: beef, pork, poultry, fish, eggs, dried beans, dried peas, and nuts (II-7)

2. 2-3 servings/day

B. Milk group (II-8)

1. Ex.: milk (whole, 2%, skim), yogurt, buttermilk, cream, ice cream, and cheese

2. 2-4 servings/day

C. Grain group (II-9)

1. Ex.: enriched or whole grain breads and cereals, crackers, pasta, and rice

2. 6-11 servings/day

D. Vegetable group (II-10)

  1. Ex.: vegetable juices, raw vegetable, raw leafy vegetables, cooked vegetables, potatoes

  2. 3-5 servings/day

E. Fruit group

  1. Ex.: canned, frozen, cooked, or raw fruits, fruit juices

  2. 2-4 servings/day

IV. Special Diets

A. Liquid - foods that are liquid

  1. Clear liquid (surgical) - measure intake if indicated

    a. Minimal residue, consists mainly of dissolved sugar and flavored fluids, no milk; not nutritionally adequate alone

    b. Examples: coffee, tea, broth, and jello

    c. Usually ordered before and after an operation

  2. Full liquid (medical) - measure intake

    a. Strained semiliquid food and any liquid

    b. Examples: fruit juice, milk, pudding, ice cream, and creamed soups (II-11)

    c. Usually ordered if client has flu or diarrhea

B. Soft

  1. Foods easily chewed

  2. Fibrous and highly seasoned foods eliminated

  3. Examples - tender chopped or ground meat, poultry, and well-cooked peeled fruits and vegetables

C. Diabetic - requires closer monitoring (II-12)

  1. Ordered for client with diabetes mellitus

    a. Diabetes mellitus is a chronic disease in which there is a deficiency of insulin in the body.

b. A lack of insulin causes sugar to build up in the blood stream and this sugar cannot be used by the cells for energy.

2. Since carbohydrates are broken down into sugar during digestion, the amount of carbohydrates is controlled with the diabetic diet.

3. The doctor determines the diabetic diet, which is the amount of carbohydrates, fats, proteins, and calories that a client should have.

4. The calories and nutrients allowed are divided among three meals and between-meal nourishments.

5. The client must eat only what is allowed and all that is allowed.

6. The American Dietetic Association provides food lists that have equal value in terms of nutrients and calories.

    a. The foods are grouped into six lists: milk, vegetables, fruits, bread, meat, and fat. These lists are called "Exchange List."

    b. The exchanges allow variety in menu planning.

7. Diabetics must eat at regular intervals to maintain a certain blood sugar level. The tray must be served on time.

8. The health care assistant must check the tray and report what food has been eaten. If all food is not eaten, a between-meal nourishment may be needed.

D. Bland

1. No roughage; easily digested and low in spices - example: mashed potatoes, cream of wheat

2. Ordered for clients with ulcers or irritated digestive tracts

E. Low salt (low sodium)

1. Salt occurs naturally in food. This diet eliminates salty food and salt added to food.

2. Sodium is a mineral that helps regulate the body's water balance.

3. No table salt on tray or table

4. Check with charge nurse before giving client a salt substitute. (High potassium)

F. Low cholesterol - eliminates animal fats from diet, allows some types of vegetable fats

V. Nutritionally Complete Liquid Diets

A. Oral

1. Given by mouth for client to drink

2. May be a supplement to regular diet or may be the only nutrition the client takes in

3. May be commercially prepared, such as Ensure® or Sustagen®

B. Tube feedings

1. Given by a tube inserted into the nose that goes down the esophagus into the stomach (NG tube) or by a tube that goes directly into the stomach (G tube); head of bed is elevated during administration; intake and output are recorded

2. May be a supplement to regular diet or may be the only nutrition the client takes in

VI. Non-Nutrients **(II-13)**

A. Fiber

1. The non-nutritive part of plant food--the indigestible part

2. Provides bulkiness to the stool--the softer the stool is, the easier it is to eliminate, thus preventing constipation

NOTE: See Lesson 37 for more detailed information on conditions that cause abnormal bowel function.

3. Sources - whole wheat, bran, outside of corn kernels and peas, fruit and potato skins

B. Water

1. Water is essential to life; a person can live only a few days without water. It provides minerals but no other nutrients. The body requires 2,000 to 3,000 cc daily.

2. Sixty percent of the human body is water.

3. Fluid intake must match what is lost by urination, defecation, perspiration, respiration, vomiting, drainage from wounds, hemorrhage, and extensive burns.

4. Illness may upset water balance.

5. Dehydration is an excessive loss of water from body tissues. Symptoms may include: thirst, although the elderly often do not get "thirsty" (which is why water should be offered frequently); dryness of skin and mucous membranes (inside of nose and mouth); constipation; little or no urination; fall in BP; rise in temperature; loss of tissue elasticity; dizziness and mental confusion.

   CAUTION: When these symptoms are observed, the person is in advanced dehydration and at risk. (II-14)

6. Edema occurs when there is too much fluid in the tissue. Symptoms include swelling, shortness of breath, increase in weight, decrease in urine.

7. An elderly client with an indwelling catheter should have up to 3,000 cc of fluid to maintain the flow of urine and prevent bladder infections unless contraindicated.

VII. Nutritional Needs of the Elderly Client (II-15)

A. USDA recommended servings for older women:

1. Grain group - 6 servings
2. Fruit group - 2 servings
3. Vegetable group - 3 servings
4. Milk group - 2 servings
5. Meat group - 2 servings
6. Modest amount of fat and sweets providing about 1600 calories a day

B. USDA recommended servings for older men:

1. Grain group - 9 servings
2. Fruit group - 3 servings
3. Vegetable group - 4 servings
4. Milk group - 2 servings
5. Meat group - 2 servings

C. The number of calories needed depends on body size and activity for both men and women.

D. If appetite is poor, offer smaller, more frequent meals.

VIII. Summary and Conclusion

A. Terms and definitions

B. Five categories of nutrients

C. Basic food groups

D Special diets

E. Nutritionally complete liquid diets

F. Non-nutrients

G. Nutritional needs of the elderly client

You should now have an understanding of the importance of diet for the clients as well as for yourself. If nutritional needs are not being met, problems will arise. Take note of the food you serve to the clients and how it fits into a well-balanced diet. Also note what foods you should encourage the client to eat. The next lesson is on measuring weight and height of clients.

LESSON PLAN: 31

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What do digestion, nutrient, peristalsis, residue, and roughage mean?
2. What are the five categories of nutrients and their functions?
3. Name some foods that are high in protein.
4. What are some examples of foods high in carbohydrates?
5. What are some examples of foods high in fats?
6. What are the basic food groups?
7. How many servings per day are recommended for each of the basic food groups?
8. What foods are included in the meat food group?
9. What foods are included in the milk food group?
10. What foods are included in the grain food group?
11. What foods are included in the fruit food group and vegetable food group?
12. What foods are included in a full liquid diet?
13. Why is close monitoring required of the client receiving a diabetic diet?
14. What are two non-nutrients?
15. Why are fiber and water important in the diet?
16. How do elderly clients' nutritional needs differ from your nutritional needs?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Assign students to keep a food intake chart for one day and classify foods in each food group.
2. Have guest dietitian speak to class on nutritional needs of the older adult.
3. Show audiovisuals.

ANSWERS TO EVALUATION ITEMS:

1. f
2. g
3. e
4. d
5. b
6. a
7. c
8. d
9. e
10. b
11. a
12. c
13. b
14. c
15. b
16. c
17. d
18. b
19. b
20. a
21. d
22. d
23. a
24. c

LESSON PLAN: 31

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

Match each term in Column I to the correct definition in Column II.

Column I

___ 1. Peristalsis
___ 2. Defecation
___ 3. Roughage
___ 4. Nutrient
___ 5. Residue
___ 6. Digestion
___ 7. Nutrition

Column II

a. Process by which food is broken down, mechanically and chemically, and changed to a form that can be absorbed by the body

b. What remains of something after a part is removed

c. The process of taking in food and producing energy from it

d. Food that supplies the body with its necessary elements

e. Indigestible fiber of fruits, vegetables, and cereal which acts as a stimulus to aid intestinal peristalsis

f. Wave-like movements of the digestive tract which move food through

g. Passing of stool

Match the categories of nutrients in Column I with the correct function in Column II.

Column I

___ 8. Protein
___ 9. Carbohydrates
___ 10. Fats
___ 11. Vitamins
___ 12. Minerals

Column II

a. Important for the proper breakdown and use of other nutrients

b. Stored as energy for later use

c. Regulate many body processes

d. Build and repair tissue

e. A source of energy

13. Foods included in the meat group are: (Circle the letter of the best answer.)

a. Whole grains and pasta
b. Fish, dried beans, and eggs
c. Salad oil and butter
d. Fruit and vegetables

14. Foods included in the basic nutrient category of carbohydrates are: (Circle the letter of the best answer.)

a. Nuts and whole milk
b. Fish, dried beans, and chicken
c. Cereal, bread, and fruit
d. Salad oil and whole milk

15. Fats include which of the following foods? (Circle the letter of the best answer.)

a. Lettuce and radishes
b. Salad oil and butter
c. Fish and baked potato
d. Orange juice and apple

16. How many servings per day are recommended from the vegetable group? (Circle the letter of the best answer.)

a. 2 servings a day, each 2-3 ounces
b. 1 serving a day, each 4 ounces
c. 3 to 5 servings per day
d. 7 servings per day

17. A liquid diet includes which of the following foods? (Circle the letter of the best answer.)

a. Ground hamburger and peeled peaches
b. Cake and bread
c. Green beans and corn
d. Broth and jello

18. Which of the following statements is true concerning the diabetic diet?

a. The diabetic should eat at irregular intervals.
b. The diabetic must eat only what is allowed and all that is allowed.
c. The amount of roughage is controlled in the diabetic diet.
d. The diabetic is never given between-meal nourishment.

Match the Special Diet in Column I with the food allowed on that diet in Column II.

Column I	Column II
____ 19. Bland	a. Tender chicken breast
____ 20. Soft	b. Mashed potatoes
____ 21. Full liquid	c. Broth and jello
	d. Ice cream and pudding

22. A method of providing a nutritionally complete liquid diet is: (Circle the letter of the best answer.)

    a. Given by intravenous (IV) feedings.
    b. Grind food before giving.
    c. Offer only soft foods.
    d. Give a supplement such as Ensure.

23. Fiber, a non-nutrient, is important in the diet because: (Circle the letter of the best answer.)

    a. Fiber provides bulk to the stool.
    b. Fiber makes the stool liquid.
    c. You can live only a few weeks without water.
    d. Water is essential to life.

24. Which of the following statements is true about the nutritional needs of the elderly? (Circle the letter of the best answer.)

    a. Frequent desserts are served because the client likes them best.
    b. Larger portions are served so that the client has more choice in what is eaten.
    c. Smaller, more frequent meals are served if the client's appetite is poor.
    d. Larger amounts of sweets are offered to improve the client's appetite.

GENERAL NUTRITION

The body depends on food for energy, growth, repair of tissue, and the maintenance and regulation of many functions. Each nutrient furnished by food has a specific contribution to good health. The use of any one nutrient by the body is dependent on a proper balance of all the other nutrients to accomplish its purpose. The more variety there is in the choice of food, the better the diet is likely to be.

Energy needs must be met to maintain a healthy body. Food energy values and allowances are expressed in Kilo-Calories and will be referred to as calories throughout this manual. The energy allowance for each population and age group varies. The average needs of people in each category are expressed in the Recommended Dietary Allowance (RDA) Table.

It is important to maintain desirable body weight throughout life and this is done through a balance between energy intake and energy output. A large number of individuals in the United States are overweight and may require less energy than is recommended because they have sedentary work and leisure patterns. Energy intake should be adjusted for the individual to maintain desirable body weight in relation to age, sex, height, and physical activity.

Energy may be derived from any reasonable combination of carbohydrate, fat, and protein. An additional source of energy is alcohol.

Carbohydrate

Carbohydrate is the main source of energy in the diet. A reasonable proportion, 45-55 percent, of a person's caloric intake should be derived from carbohydrates. Foods such as fruits, vegetables, and whole-grain cereals provide energy mainly from carbohydrate and are generally good sources of other nutrients, such as vitamins and minerals. The principal carbohydrates are sugars, starches, and cellulose. The sugars include the monosaccharides and disaccharides in refined sugars, jams, jellies, syrups, honey, fruits, soft drinks, and milk. The starches are the polysaccharides of cereals, flour, potatoes, and other vegetables. Dietary fiber is generally defined as the sum of the indigestible carbohydrate and carbohydrate-like components of food, including cellulose, lignin, hemicellulose, and pectin.

Fat

Another source of energy in the diet is fat. Dietary fat also serves as a carrier for fat-soluble vitamins and provides essential fatty acids. Total fat intake should comprise no more than 35 percent of dietary energy. Food sources of fat include butter, margarine, oils, lard, and fat in meat, poultry, fish, and dairy products. Essential fatty acids, the primary one being linoleic acid, must be provided in the diet because of the multiple functions they perform. Linoleic acid is found widely in varying amounts in foods of both plant and animal origin.

Protein

Another source of energy in the diet is protein. Protein foods can be used as an energy source but more importantly, food proteins provide amino acids for the synthesis of body proteins and for the synthesis of many other tissue constituents. Amino acids obtained from food proteins are essential for growth. Nine essential amino acids are not synthesized by the body and therefore must be provided by foods in the diet. Animal products--eggs, milk, meat, fish, and poultry--contain all of the essential amino acids in the correct proportion. Grains and legumes also furnish protein but are low in some essential amino acids.

Vitamins and Minerals

Vitamins and minerals serve many functions. Vitamins are a group of organic compounds in foods that are needed in minute quantities, and are essential for specific body functions of maintenance, growth and reproduction. Vitamins are classified as either fat soluble or water soluble. Minerals are subdivided into two categories: 1) macro-nutrients--those occurring in appreciable amounts accounting for most of the body content of minerals such as calcium--and 2) micronutrients or trace elements--those present in minute quantities, such as iodine or iron. Mineral elements are components of the body's structure or constituents of enzymes and hormones. They serve as regulators of body fluids and are involved with other body functions.

Fiber

A normal, healthy diet should contain 20-25 grams of dietary fiber. Dietary fiber is generally defined as the sum of the digestible carbohydrate and carbohydrate-like components or food including cellulose, lignin, hemicellulose, pentosans, gums, and pectin. These nondigestible substances provide bulk in the diet and aid elimination. (See Appendix.)

Water

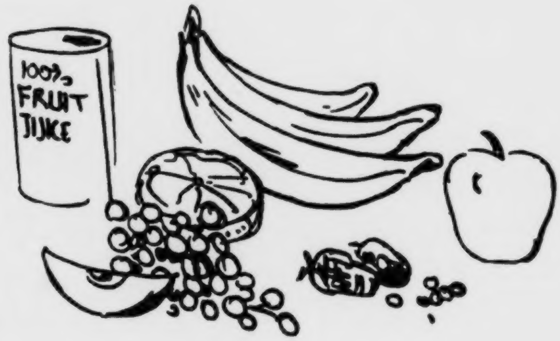
Water is an essential part of the diet for it plays a role in practically all body processes, and is the most abundant body constituent. The body is equipped with a number of homeostatic mechanisms, including the sensation of thirst, that operate to maintain total body water within narrow limits. Water is present in practically all foods.

Food groupings have been made and general guidelines established which recommend the appropriate number of servings from each of the food groups, so that an adequate amount of minerals and vitamins are provided in the daily diet. The elimination of one food group might appreciably reduce the intake of one or more of the minerals and vitamins.

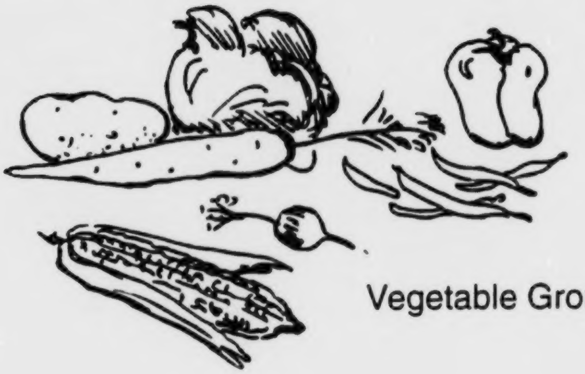
The manner in which foods are selected, prepared, and served affects their contribution to the diet. Care must be taken to select a variety of foods, prepare them in a manner to preserve their nutrient content, prevent food spoilage or contamination, and serve them attractively.

Source: Missouri Diet Manual. 7th ed. Missouri Department of Health and Missouri Department of Social Services - Division of Aging.

THE BASIC FOOD GROUPS


100% FRUIT JUICE

Fruit Group



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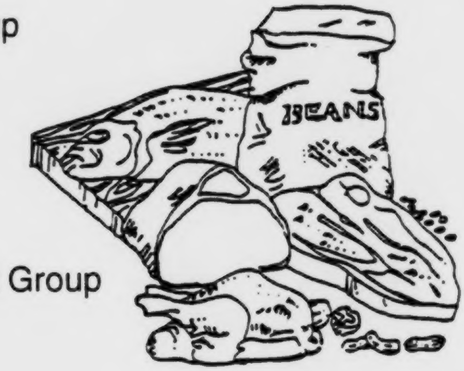
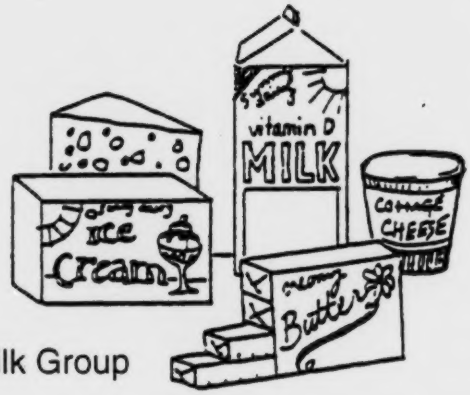
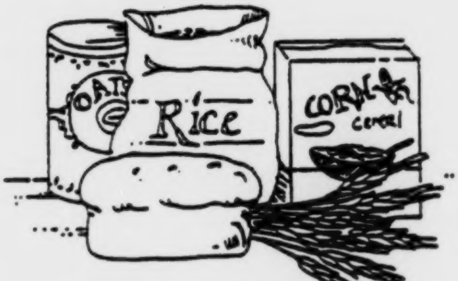


Meat Group


vitamin D
MILK
Ice Cream
Cottage Cheese
Butter

Milk Group


OATS
Rice
CORN cereal

Grain Group

BASIC FOOD GROUPS

The food groups provide a pattern to use as a guide when planning menus. The minimum number of servings specified from each group, if well chosen, forms the foundation of a nutritionally adequate diet. Use of additional servings from these groups along with the "other" foods may be needed if caloric need is greater.

MEAT GROUP

The meat group includes meat (beef, veal, pork, lamb, and wild game); fish and shellfish; poultry; eggs; and legumes such as dry beans and lentils; and nuts.

A serving from this group equals:

- 2-3 ounces lean meat, fish, or lean poultry
- 1 egg
- 2 tablespoons peanut butter
- 1/2 cup nuts
- 1/2 cup of cooked dried beans, peas, or lentils

Meat, fish, poultry, and eggs provide high quality protein. Dry beans and peas, soy extenders, and nuts by themselves are incomplete proteins (amino acids). Foods containing dry beans, dry peas, or nuts should be combined with grain or animal protein to enhance protein utilization (e.g., bean burrito with cheese and peanut butter sandwich). This group also supplies fat, iron, niacin, and other nutrients.

MILK GROUP

The milk group contains all types of milk used as beverages, all kinds of natural or processed cheese, cottage cheese, yogurt, ice cream, and foods made with large proportions of milk such as cream soups and puddings.

The recommended servings of milk vary for different groups of people because nutrient needs vary with body size and the stage of growth. A serving from this group equals:

- 1 cup or 8 ounces whole, 2 percent, or skim milk, buttermilk; reconstituted nonfat dry or reconstituted evaporated milk
- 1 1/2 to 2 ounces cheese
- 1/2 cup cottage cheese
- 1/2 cup ice cream, frozen yogurt, or ice milk
- 1 cup yogurt

Milk is the best source of calcium and riboflavin, and is an important source of vitamins A and D and high quality protein. Milk provides carbohydrate, fat (unless nonfat milk is used), and other nutrients.

GRAIN GROUP

The grain group includes all grains--such as barley, buckwheat, corn, oats, rice, rye, and wheat--bread, breakfast cereals, grits, noodles, and pasta products made from grains. Each of the following is equal to one serving from the grain group:

1 slice whole-wheat or enriched bread
1 tortilla
1/2 English muffin or hamburger bun
1 oz. ready-to-eat cereal
1/2 cup cooked cereal, rice, grits, or pasta
1 roll, muffin, or biscuit

Labels should be checked carefully to assure that the products are enriched, fortified, or whole-grain. Enriched grains provide iron, thiamin, riboflavin, and niacin, and are the main source of carbohydrate. Whole-grain foods, such as whole-wheat bread, oatmeal, and shredded wheat, provide more fiber, zinc, folic acid, and vitamins B6 and E than other breads and cereals. Milk combined with grains improves the usability of grain proteins for body repair and building. (e.g., cereal with milk; cheese and rice casserole.)

FRUIT GROUP

The fruit group includes all fresh, frozen, and dried fruits. The fruit group is a good source of vitamin C. Two to four servings are needed daily. Each of the following is equal to one serving from the fruit group:

3/4 cup fruit juice
1/2 cup raw, canned, or cooked fruit
1 medium apple, banana, orange or pear
1/2 grapefruit
1/4 cantaloupe

VEGETABLE GROUP

The vegetable group is a rich source of vitamin A. Three to five servings are needed each day. Each of the following is equal to one serving from the vegetable group:

3/4 cup vegetable juice
1/2 cup raw vegetable
1 cup raw leafy vegetable
1/2 cup cooked vegetable
1 medium potato

Some foods don't have enough nutrients to fit in any of the above food groups. These foods are called "Others." These foods are okay to eat in moderation. They should not replace foods from the Five Food Groups. The "Others" category includes fats and oils, sweets, salty snacks, alcohol, other beverages, and condiments.

BEVERAGES AND FLUIDS

This group supplies no significant nutrients, but does supply water. Coffee, tea, and sugar-free carbonated beverages are contained in this group. Carbonated and alcoholic beverages provide carbohydrates and alcohol, and may contribute significant calories.

Suggested Weights for Adults

Height[1]	Weight in pounds[2]	
	19 to 34 years	35 years and over
5'0"	[3]97-128	108-138
5'1"	101-132	111-143
5'2"	104-137	115-148
5'3"	107-141	119-152
5'4"	111-146	122-157
5'5"	114-150	126-162
5'6"	118-155	130-167
5'7"	121-160	134-172
5'8"	125-164	138-178
5'9"	129-169	142-183
5'10"	132-174	146-188
5'11"	136-179	151-194
6'0"	140-184	155-199
6'1"	144-189	159-205
6'2"	148-195	164-210
6'3"	152-200	168-216
6'4"	156-205	173-222
6'5"	160-211	177-228
6'6"	164-216	182-234

[1] Without shoes.

[2] Without clothes.

[3] The higher weights in the ranges generally apply to men, who tend to have more muscle and bone; the lower weights more often apply to women, who have less muscle and bone.

Credit: Dietary Consultant, Missouri Division of Aging, P.O. Box 1337, Jefferson City, MO 65102

LESSON PLAN: 32

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-32 AND DEMONSTRATION: VII-32

MEASURING WEIGHT AND HEIGHT
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. List two types of scales that can be used to weigh a client.
2. Identify key points in weighing the client.
3. Identify key points in measuring height of a client in bed and on an upright scale.
4. Convert a measurement of inches into feet and inches.
5. Explain how much weight gain or loss in one month should be reported to the charge nurse.

Demonstration

6. Measure weight and height of client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Bathroom Scale, Upright Scale
2. Scale
3. Paper Towel

4. Paper and pencil

5. Measuring Weight, video #12, available from the Missouri Vocational Resource Center (13 min.)

6. Projector

7. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 32 (Student Reference page 497) prior to class and be prepared to discuss the information presented and perform the procedure of measuring the weight and height of a client according to the steps of procedure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 17.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 17.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 4, Section 4.

INTRODUCTION:

Clients are weighed upon admission to a health care facility. In long-term care, clients are also weighed once a month, unless the charge nurse instructs you to weigh the client more often. A weight loss or gain can be significant and should be reported. The client's height is measured only once on admission since this does not usually change. As with many other procedures, accuracy is very important.

LESSON PLAN: 32

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

OUTLINE:

I. Types of Scales (II-1)
  - A. Bathroom - portable
  - B. Upright scale
  - C. Chair - Hoyer lift with sling
  - D. Bed - stretcher
  - E. Platform scale

II. Weighing the Client
  - A. Scales will vary from place to place in the facility. Always use the same scale when weighing the client.
  - B. The weight of a person may vary during the day so perform the procedure at the same time each day. (II-2)
  - C. Clients should be weighed with their shoes off and with as little clothing on as possible. (II-3)
  - D. The best time to get an accurate weight is before the client has had anything to eat or drink in the morning. Have the client urinate before weighing. (II-4)
  - E. If a client has a brace, artificial limb, or heavy clothing, subtract the weight of the clothing or appliance, if possible. If not, record that it was on when the client was weighed. (II-5)
  - F. If the client cannot stand and is in a W/C or G/C use a platform scale and weigh the chair first, then weigh the client in the chair. Subtract the weight of the chair. (II-6)
  - G. You may put a walker in place around the scale for the client to use for support when stepping onto the scale.
  - H. The long lines of the scale indicate one pound; each short line indicates one fourth pound. (HO 1) (II-7)
  - I. To convert from kilograms to pounds, multiply the number of kilograms by 2.2.

J. To convert from pounds to kilograms divide the number by 2.2.

III. Measuring Height of Client

  A. In bed

    1. Client should be in supine position, with the bed flat. (II-8)

    2. Use a tape measure and measure from the top of the head to the soles of the feet.

    3. An approximate height can be measured by stretching the arms out from the sides and measuring from third finger to third finger across the top of the body.

  B. On an upright scale

    1. A height measurement rod is read in inches and the inches should then be converted to feet and inches. One foot is equal to 12 inches. To convert from inches to feet, divide the number of inches by 12.

      a. 12 inches = 1 foot (II-9)

      b. 48 inches = 4 feet

      c. 60 inches = 5 feet

      d. 72 inches = 6 feet

    2. Measuring rod has long lines that indicate every one inch; short lines indicate one-fourth inch.

IV. Reporting and Recording Weight

  A. Compare weight to previous record.

  B. A gain or loss of five pounds or more should be reported to the charge nurse. (II-10)

V. Demonstrate Procedures for Measuring Weight and Height of Clients.

VI. Summary and Conclusion

  A. Types of scales

  B. Weighing the client

  C. Measuring height of a client

  D. Reporting and recording

E. Review procedures for measuring weight and height.

The next lesson is on serving, feeding, and monitoring clients.

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LESSON PLAN: 32

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

STEPS OF PROCEDURE FOR MEASURING WEIGHT AND HEIGHT:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Place a paper towel on the scale platform.
7. Raise the measuring rod.
8. Ask the client to remove robe and slippers; provide assistance if necessary.
9. Assist the client to stand on the scale platform; have client stand with arms to sides.
10. Read the weight.

    NOTE: If using a balance scale, move the weight until the pointer swings evenly between the top and bottom of the metal square.
11. Record weight.
12. Instruct the client to stand erect.
13. Lower the measuring rod until it rests on the client's head.
14. Read the height and record it on paper. Raise measuring rod.
15. Assist client off the platform. Assist client in putting on his/her robe and slippers. Assist to his/her bed or chair.
16. Discard the paper towel.
17. Remove, clean, and store equipment.
18. Wash your hands.
19. Make the client comfortable; place call signal within reach.
20. Record observations and report anything unusual to the charge nurse.

LESSON PLAN: 32

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What types of scales can be used to weigh a client?
2. Why do you weight a client at the same time each day?
3. What type of clothing should clients be wearing when you weigh them?
4. What is the best time of day to weigh a client?
5. What do you do if you weigh a client with an artificial leg?
6. How do you weigh a client in a wheelchair?
7. What do the long lines on a scale indicate?
8. What position is the client in when you measure him/her in bed?
9. If a client measures 58 inches, how many feet and inches is he/she? 63 1/2 inches? 74 1/4 inches?
10. How much weight gain or loss in one month should be reported to the charge nurse?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates the procedure to measure weight and height of a client.
2. Students practice measuring weight and height of each other.

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:
    a. Bathroom - portable
    b. Upright scale
    c. Chair - Hoyer lift with sling
    d. Bed - stretcher
    e. Platform scale

2. c
3. d
4. c

5. b
6. a
7. d
8. a
9. d

LESSON PLAN: 32

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

1. List two types of scales that can be used to weigh a client.

   a.

   b.

2. When weighing Mr. Jackson, you should: (Circle the letter of the best answer.)

   a. Weigh him with his shoes on so that his feet will not get cold.
   b. Weigh Mr. Jackson immediately after breakfast to get the true weight with fluids and food.
   c. Weigh Mr. Jackson at the same time each day.
   d. Weigh Mr. Jackson and add the weight of any appliance he is carrying.

3. What do the long lines on a scale indicate? (Circle the letter of the best answer.)

   a. 1/4 pound
   b. 1/2 pound
   c. 3/4 pound
   d. 1 pound

4. To accurately weigh a client who is in a wheelchair, you should: (Circle the letter of the best answer.)

   a. Use the lightest wheelchair available on the unit.
   b. Weigh the person, then weight the wheelchair and add the two weights.
   c. Weigh the wheelchair by itself, then the wheelchair with the client in it, and subtract the wheelchair weight from the total weight.
   d. Weigh the wheelchair with the person in it, then ask the client what his/her weight is, and subtract the person's weight from the total weight.

5. If a client and a wheelchair weigh a total of 210 pounds and the wheelchair weighs 30 pounds by itself, how much does the client weigh? (Circle the letter of the best answer.)

   a. 110 pounds
   b. 180 pounds
   c. 210 pounds
   d. 240 pounds

6. When measuring a client in bed, the client should be in the: (Circle the letter of the best answer.)

   a. Supine position.
   b. Transverse position.
   c. Fowler position.
   d. Semi-fowler position.

7. What do the long lines indicate on the height measuring rod? (Circle the letter of the best answer.)

   a. Feet
   b. 12 inches
   c. 6 inches
   d. 1 inch

8. If Mrs. Scott's height measures 66 inches, she would be how tall in feet and inches? (Circle the letter of the best answer.)

   a. 5 feet 6 inches
   b. 5 feet 3 1/2 inches
   c. 5 feet 2 inches
   d. 4 feet 10 inches

9. A loss or grain of how many pounds is considered significant and should be reported immediately to the charge nurse? (Circle the letter of the best answer.)

   a. 1 pound
   b. 3 pounds
   c. 4 pounds
   d. 5 pounds

LESSON PLAN: 32

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ________________

MEASURE WEIGHT AND HEIGHT

EQUIPMENT:

1. Upright scale with measuring rod
2. Paper towel
3. Paper and pencil

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Place a paper towel on the scale platform.		
7. Raise the measuring rod.		
8. Ask the client to remove robe and slippers; provide assistance if necessary.		
9. Assist the client to stand on the scale platform; have client stand with arms to sides.		
10. Read the weight. NOTE: If using a balance scale, move the weight until the pointer swings evenly between the top and bottom of the metal square.		
11. Record weight.		
12. Instruct the client to stand erect.		
13. Lower the measuring rod until it rests on the client's head.		
14. Read the height and record it on paper. Raise measuring rod.		
15. Assist client off the platform. Assist client in putting on his/her robe and slippers. Assist to his/her bed or chair.		

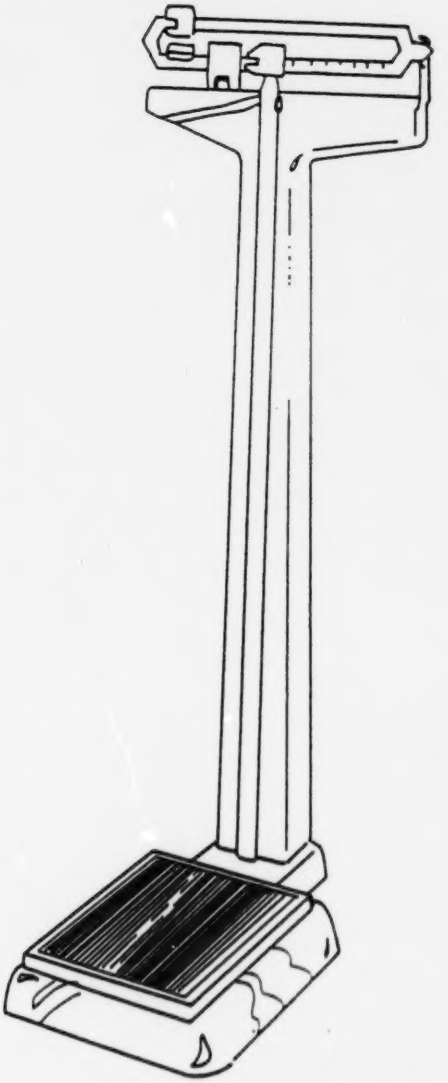
16.	Discard the paper towel.		
17.	Remove, clean, and store equipment.		
18.	Wash your hands.		
19.	Make the client comfortable; place call signal within reach.		
20.	Record observations and report anything unusual to the charge nurse.		

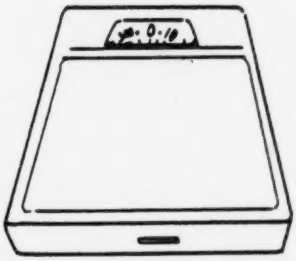
The student has satisfactorily completed the procedure "MEASURE WEIGHT AND HEIGHT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

BATHROOM SCALE, UPRIGHT SCALE





LESSON PLAN: 33

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-33 AND DEMONSTRATION: VII-33

SERVING, FEEDING, AND MONITORING
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms in this lesson with correct definitions.
2. Identify considerations involved with preparing clients for mealtime.
3. Explain how to prepare and serve food trays.
4. Identify key points in assisting a client to eat.
5. Identify key points in feeding a client.
6. Describe after-meal care for a client.
7. Identify key points in meeting nutritional needs of clients with special eating problems.
8. Identify observations to report for clients receiving feedings by tubes.

Demonstration

9. Feed a helpless client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Adaptive Equipment
2. HO 2: Food Tray for the Blind Client
3. HO 3: Nasogastric Tube
4. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Feeding is Everybody's Business, slides/cassette (TF #72), 35 min.
    b. Caring for the Tube Fed Patient, video (TF #79), 28 min.
5. Television and VCR
6. Projector
7. Food tray
8. Napkin or towel
9. Overbed table
10. Chair

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 33 (Student Reference page 507) prior to class and be prepared to discuss the information presented and be prepared to demonstrate ability to feed a client according to procedure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 20.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 24.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 10.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 9.

INTRODUCTION:

Think about everything people do to get ready for a meal. We usually go to the bathroom, wash our hands, straighten our clothes, clear the dining area of unpleasant sights and smells, and do various other things to make mealtime a pleasant time. Our clients would like the same consideration. In this lesson, we will discuss serving, feeding, and monitoring the client in ways that will make mealtime a pleasant experience so that he/she will be more inclined to eat properly. We will also practice feeding a client.

LESSON PLAN: 33

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

OUTLINE:

I. Terminology (II-1)

  A. Nutrition - the process whereby the body takes in food for growth and repair

  B. Intravenous infusion (IV) - nutrients are given through the vein

  C. Flow rate - the rate which IV solution enters the body; measured in drops per minute

  D. Nasogastric tube - a tube which is inserted through the nose and down into the stomach; commercial formulas are given through the tube

  E. Gastrostomy tube - a tube inserted through the abdominal wall into the stomach

  F. Gavage - tube feeding

  G. Anorexia - loss of appetite

II. Considerations Involved in Preparing a Client for Mealtime. (II-2)

  A. Offer bedpan or urinal or assist to bathroom or remind client to go to the bathroom.

  B. Wash client's hands or remind him/her to wash hands.

  C. Make sure dentures, glasses, and hearing aid are cleaned and are properly in place.

  D. In long-term care facilities, assist client to dining room, if indicated on care plan.

    1. Assist to chair and position at table.

    2. Protect clothing with napkin or towel--do not refer to it as a "bib."

    3. Cover unsightly medical appliances, such as urinary catheter bags.

  E. If client is unable to go to the dining room, assist to chair, if indicated on care plan. (II-3)

1. Position client comfortably with overbed table in convenient position.

2. Protect clothing with napkin or towel.

F. If client is unable to get out of bed

1. Elevate head of bed and position client in as near a sitting position as possible with overbed table in convenient position.

2. Protect clothing with napkin or towel.

G. Prepare the surroundings of the client. (II-4)

1. Put away unsightly equipment.

2. Remove smells of recent BM by airing room. Odors that remain indicate a cleaning problem.

3. Place fresh glass of water within reach at all times.

4. Straighten linens.

H. Provide privacy for clients who have unpleasant eating habits.

III. Preparing and Serving Food Trays (II-5)

A. Check name (and room number) to make sure client gets correct tray.

B. Make certain there is a menu card on the tray.

C. Check tray to make sure everything is on it according to posted menu and client's diet order.

D. If client cannot eat when tray is served, take it to away and keep it warm. (II-6)

E. Serve trays promptly so food temperature is maintained.

F. Serve one tray at a time to avoid contamination of second tray in another client's room.

G. Carry tray at waist level; not on shoulder next to hair. (II-7)

H. See that each client who should have a tray receives one. If a client does not have a tray upon completion of tray pass, notify charge nurse.

I. See that the general appearance of the tray is orderly and tidy.

J. Trays must be served and clients fed promptly upon delivery of tray.

IV. Assisting the Client to Eat

A. Place the tray on the table with main dish closest to the client. **(II-8)**

B. Arrange everything so the client can reach it.

C. Remove food covers and put them to one side or return them to the kitchen. **(II-9)**

NOTE: Do not place covers on floor or on utility carts.

D. Open milk cartons, cereal boxes, and anything else that may be difficult for the client to manage if the client requires or requests help. **(II-10)**

E. Help client with cutting food, buttering bread, pouring liquids, etc.

F. Provide a straw for the client who is unable to use a cup.

G. Encourage clients to do as much for themselves as possible.

H. Use adaptive equipment as necessary for the client to be able to eat on his/her own according to care plan. (HO 1)

1. Built-up utensils
2. Plate guards
3. Band to hold utensils
4. Drinking cup
5. Knifork
6. Swivel spoon or fork
7. Extended handles
8. Pencil clip for straw

I. Stay with client until you are certain he/she can manage independently.

J. Note and record amount of food eaten; report change of appetite to charge nurse.

K. Note foods client is not eating and report findings to charge nurse.

L. Report the foods not eaten by a diabetic client to the charge nurse.

V. Feeding a Client

A. Place tray so client can see food.

B. Protect client and bed linens with towel or napkin.

C. Health care assistant should be in sitting position while feeding the client (II-11)

NOTE: It is permissible to sit beside the client when feeding him/her.

D. Avoid rushing or hurrying the client.

E. Describe the meal if client is unable to see it.

F. Use a straw for giving liquids.

G. Encourage client activity--have him/her hold bread, grasp glass, etc.

H. Fill spoon half-full to avoid spilling and to give manageable amounts of food.

I. Serve food in order of client's preference (get a substitute from Dietary Department).

J. Offer liquids and solids alternately to provide moisture for chewing.

K. Give client sufficient time to chew and swallow food thoroughly, as well as time to breathe between bites.

L. Season food as client wishes unless there are special diet restrictions.

M. Tell the client what each bite is as offered.

N. Warn clients when offering something hot.

O. Keep conversation friendly and discuss pleasant subjects.

P. Wipe mouth as needed and when finished.

VI. After-Meal Care (II-12)

A. Take tray away when client is finished eating. Report comments regarding food to charge nurse.

B. Do not leave dirty dishes in front of client.

C. Make sure client's clothing is clean, change if soiled by spilled food.

D. In long-term care facilities, assist client from dining room to his/her room.

1. Wash face and hands.

    2. Assist with or remind client of mouth care.
    3. Encourage participation in an activity.
- E. Assist client back to bed from chair in room.
    1. Wash face and hands.
    2. Assist or give mouth care.
    3. Make comfortable and place signal light within reach.
- F. Lower backrest if client is in bed.
    1. Wash face and hands.
    2. Assist or give mouth care.
    3. Position comfortably and place signal light within reach.
- G. Put personal articles where client can reach them.
- H. Note how much and what the client eats. Record the percentage of food eaten. Any changes in eating habits can signal changes in physical condition--report to charge nurse.
- I. Wash your hands.

VII. Clients with Special Eating Problems

- A. Client with paralysis or weakness of muscles used for eating
    1. Client should be sitting in upright position to aid swallowing; gag and cough reflexes may be absent, making it easier for client to choke.
    2. Feed into side of mouth that is not paralyzed. **(II-13)**
    3. Remind the client to think about swallowing.
    4. Give small amounts of food and allow the client plenty of time to chew.
    5. With gloved hand, clean out paralyzed side of mouth frequently with a swab.
- B. Blind client
    1. Identify everything on the tray.

2. Identify placement of food on tray by comparing to positions of the hour hand on a clock (milk at 2:00, meat at 6:00, etc.). Placement should be the same at each meal. (HO 2) **(II-14)**

3. Warn client which liquids are hot.

4. Tell client where utensils are.

C. Comatose, unconscious, or unresponsive client

1. Do not give oral liquids or food.

2. Clients will often receive nutrition by another method, such as tube feeding.

3. Nasogastric tube feeding for long-term nutrition performed by the nurse; note the following: (HO 3)

   a. Keep head of bed elevated approximately 30 degrees to prevent regurgitation (return of solids or fluids to the mouth from the stomach).

   b. Client needs frequent mouth care (every 2 hrs.).

   c. Keep nostrils clean.

   d. Inform nurse if tape holding tube in place becomes loose.

D. Client in isolation

1. Follow facility's isolation procedure. If you don't know, ask.

2. Paper dishes are usually used.

3. If metal or china utensils are to be used, check with charge nurse about how they are to be handled.

4. Special instruction in isolation techniques shall be given to the health care assistant by charge nurse when this becomes necessary in a health care facility.

VIII. Feeding with Tubes

A. Types of feedings

1. Intravenous (IV)

2. Gastrostomy (G)

3. Nasogastric (NG)

B. Responsibilities

   1. Procedure performed by licensed personnel

   2. Health care assistant responsibility is to observe and report anything unusual.

C. General nursing care

   1. Know where the tube is and its location in the body.

   2. Make certain tubes are not coiled under the client.

   3. Check that client is comfortable.

   4. Report: (II-15)

      a. Change in vital signs

      b. Elevated temperature

      c. Redness and swelling of the site of the tube

D. Intravenous feedings

   1. Observe and report:

      a. Pain at site

      b. Swelling at site

      c. Change in skin color at site

      d. Any change in respiration or chest pain

      e. Any rash

      f. Restlessness or anxiety

      g. Leaks in tube

      h. Kinks in tube

      i. Tube tangled

      j. Tube under client

E. Gastrostomy feedings - a tube surgically inserted into the client's stomach for the purpose of instilling liquid nourishment

1. Observe and report:
    a. Drainage or skin breakdown around tube
    b. Client complaint of nausea or fullness
    c. Diarrhea or constipation
    d. Check if tube is anchored and report to charge nurse. Do not retape tube.
    e. Anything unusual about feeding
    f. Any kinks in tube

F. Nasogastric tube feeding - A tube is passed through the client's nose, down the esophagus to the stomach to provide liquid nourishment. The client is usually in the sitting position when the feeding is administered and in a position that aids digestion at the completion of the procedure.

1. Observe and report:
    a. Nausea or complaint of fullness
    b. Choking
    c. Diarrhea or constipation
    d. Anything unusual about feeding
    e. Any kinks in tube
2. Always give good mouth care to the client with nasogastric/gastric tubes to help prevent any infection of the mouth and to aid in client's comfort.

VIII. Demonstrate Feeding a Helpless Client.

IX. Summary and Conclusion

A. Terminology

B. Considerations involved in preparing a client for mealtime

C. Preparing and serving food trays

D. Assisting the client to eat

E. Feeding a client

F. After-meal care

G. Clients with special eating problems

H. Feeding with tubes

I. Review procedure for feeding the helpless client.

Keep in mind all of the things that need to be done for each client before and after each meal. The next lesson is on systems of measurements.

LESSON PLAN: 33

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

STEPS OF PROCEDURE FOR FEEDING THE HELPLESS CLIENT:

1. Wash your hands.
2. Provide before-meal care: offer client bedpan or urinal; wash client's hands and face; position client in sitting position.
3. Wash your hands.
4. Check food tray before serving to make sure it is the correct one.
5. Place food tray in front of client on overbed table.
6. Explain that you will help client eat.
7. Spread napkin or towel to protect clothes and linen.
8. Sit down in chair facing client.
9. Prepare food: cut up meat, butter bread, pour tea or coffee, etc.
10. Season food as client wishes within diet guidelines.
11. Ask client in what order he/she wants his/her food served; name each mouthful of food as you offer it.
12. Let client help self if possible.
13. Use straws or a double handled cup for liquids.
14. Use spoon to give small bites and feed slowly, allowing time for chewing, swallowing, and breathing.
15. Alternate liquids and solids.
16. Wipe client's mouth as needed.
17. Warn client when giving something hot.
18. Take tray away as soon as client is finished.
19. Note foods and amounts eaten.

20. Provide after-meal care: wash client's hands and face; remove napkin; make client comfortable; place call light within reach.

21. Wash your hands.

22. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 33

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What are the definitions of nasogastric tube, nutrition, gavage, gastrostomy tube, and flow rate?
2. What considerations are involved in preparing a client for mealtime?
3. What is the correct procedure for assisting a client to the dining room?
4. How do you prepare the surroundings for the client who must eat in his/her room?
5. What do you check before serving a tray to the client?
6. What do you do if a client cannot eat when the tray is served?
7. What is the proper way to carry a tray?
8. Where is the main dish placed when you serve a tray?
9. What do you do with the food cover when you remove it from the tray?
10. How can you assist the client with the food on his/her tray?
11. What position should the health care assistant be in when feeding the client?
12. What does after-meal care include?
13. How do you feed a client who is paralyzed on one side?
14. How is the food tray served to the blind client?
15. What observations should you report for a client receiving feedings by tube?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisuals.
2. Have students role-play serving trays to one another and feeding each other.
3. Practice using special adaptive devices designed to help a client eat.

4. Have students discuss their feelings about being served a tray with coffee spilled on their toast or gravy in their applesauce.

5. Have students practice feeding one another. Try using baby food at room temperature--it will show why food needs to be served promptly and demonstrate to students what it's like to eat food with no salt or sugar. Have some students slouch down in their chairs and try to eat. Have some students eat with their eyes closed or while blindfolded and be fed with little explanation of what they are being fed.

6. Have students practice figuring the percentage of food consumed.

ANSWERS TO EVALUATION ITEMS:

1. e
2. b
3. a
4. f
5. d
6. b
7. d
8. c
9. d
10. a
11. b
12. c
13. d
14. a
15. b
16. c
17. b

LESSON PLAN: 33

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

Column I	Column II
____ 1. Nasogastric tube	a. Tube feeding
____ 2. Nutrition	b. The process whereby the body takes in food for growth and repair
____ 3. Gavage	c. Nutrients given through the vein
____ 4. Gastrostomy tube	d. The rate which IV solution enters the body
____ 5. Flow rate	e. A tube inserted through the nose and down into the stomach
	f. A tube inserted through the abdominal wall into the stomach

6. When preparing a client for mealtime, the health care assistant should: (Circle the letter of the best answer.)

   a. Make certain eye glasses are in the bedside stand.
   b. Offer the bedpan or urinal or assist client to the bathroom.
   c. Prepare the client one hour before the meal is served.
   d. Put old clothing on the client so that the good clothes do not become stained.

7. When assisting a client to the dining room, the health care assistant should: (Circle the letter of the best answer.)

   a. Protect the clothing with a "bib".
   b. Place the urinary catheter bag where it can be seen.
   c. Ask the client if he/she is hungry.
   d. Assist the client to a chair and position the chair at the table.

8. When preparing to feed a client who is unable to get out of bed you should: (Circle the letter of the best answer.)

   a. Make certain all of the food is cold.
   b. Lower the head of the bed.
   c. Remove any odors in the room by airing the room.
   d. Place the water glass on the bed side table.

9. Which of the following statements is true when serving a meal tray to a client? (Circle the letter of the best answer.)

   a. There must be desserts on the tray.
   b. Dispose of the food immediately if the client isn't hungry.
   c. Carry two trays at the same time at shoulder level.
   d. Make certain you are serving the correct diet and amount ordered for the client.

10. Which one of the following would be the most appropriate action for you to take if the food was cold on the tray you were serving? (Circle the letter of the best answer.)

   a. Return the tray to the kitchen and request a new tray or the food be warmed.
   b. Serve the tray because food is expensive and cannot be wasted.
   c. Check if the client minds eating cold food.
   d. Tell the kitchen help to never give you a tray to deliver with cold food again.

11. When serving a tray to a client, you should: (Circle the letter of the best answer.)

   a. Remove the food covers and put them on the utility cart or floor.
   b. Help the client by opening milk cartons and cereal boxes.
   c. Place the tray with the main dish farthest from the client.
   d. Feed the client because it is faster than waiting for the client to eat.

12. When feeding a client: (Circle the letter of the best answer.)

   a. You should be in a standing position.
   b. Fill the spoon full and give large bites.
   c. Avoid rushing or hurrying the client.
   d. Offer all liquids first, then all solids.

13. After-meal care includes: (Circle the letter of the best answer.)

   a. Removing your gloves.
   b. Leaving dirty dishes for the kitchen help to pick up.
   c. Discouraging participation in activities until digestion is completed.
   d. Recording the percentage of food eaten and any change in eating habits.

14. When feeding a client with paralysis or weakness of muscles used for eating, you should: (Circle the letter of the best answer.)

    a. Feed into the side of the mouth that is not paralyzed.
    b. Feed into the side of the mouth that is paralyzed or weak.
    c. Place the client flat on the affected side.
    d. Place the client flat on the unaffected side.

15. When assisting the blind client to eat, the health care assistant should: (Circle the letter of the best answer.)

    a. Ask the client what help they needed.
    b. Identify placement of food on the tray related to the face of a clock.
    c. Place all food in a straight line across the tray.
    d. Place all hot foods toward the far side of the tray and all cold food to the near side.

16. What should the health care assistant check and report for clients receiving feeding by tube? (Circle the letter of the best answer.)

    a. If the client is still hungry after the feeding
    b. If the client likes the taste of the feeding
    c. Redness and swelling at the site of the tube
    d. Which side the client was laying on to receive the feeding

17. When a client is receiving an intravenous feeding, the health care assistant should observe and report: (Circle the letter of the best answer.)

    a. The client's complaint of nausea and fullness
    b. Pain, swelling, and change of skin color
    c. Drainage from wound
    d. The client's complaint of diarrhea or constipation

LESSON PLAN: 33

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

FEED HELPLESS CLIENT

EQUIPMENT:

1. Food tray
2. Napkins or towel
3. Overbed table
4. Chair

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Provide before-meal care: offer client bedpan or urinal; wash client's hands and face; position client in sitting position.		
3. Wash your hands.		
4. Check food tray before serving to make sure it is the correct one.		
5. Place food tray in front of client on overbed table.		
6. Explain that you will help client eat.		
7. Spread napkin or towel to protect clothes and linen.		
8. Sit down in chair facing client.		
9. Prepare food: cut up meat, butter bread, pour tea or coffee, etc.		
10. Season food as client wishes within diet guidelines.		
11. Ask client in what order he/she wants his/her food served; name each mouthful of food as you offer it.		
12. Let client help self if possible.		
13. Use straws or a double handled cup for liquids.		
14. Use spoon to give small bites and feed slowly, allowing time for chewing, swallowing, and breathing.		
15. Alternate liquids and solids.		
16. Wipe client's mouth as needed.		

17.	Warn client when giving something hot.		
18.	Take tray away as soon as client is finished.		
19.	Note foods and amounts eaten.		
20.	Provide after meal care: wash client's hands and face; remove napkin; make client comfortable; place call light within reach.		
21.	Wash your hands.		
22.	Record observations and report anything unusual to charge nurse.		

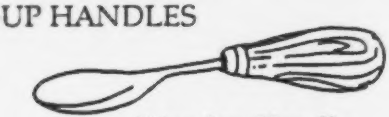
The student has satisfactorily completed the procedure "FEED HELPLESS CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

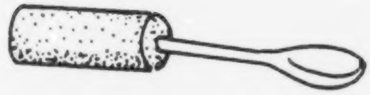
Date

ADAPTIVE EQUIPMENT

BUILT-UP HANDLES

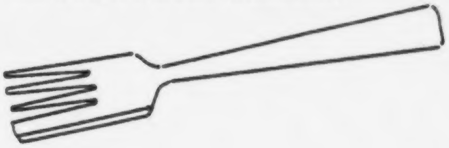


Wooden Handle

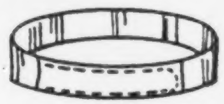


Foam Curler

CUTTER FORK (Knifork)

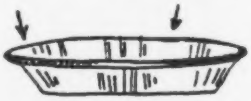


ELASTIC HOLDER

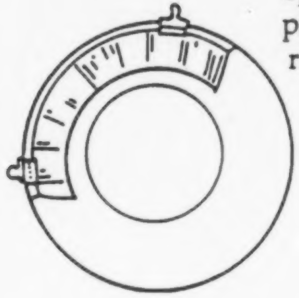


RIM ON PLATE

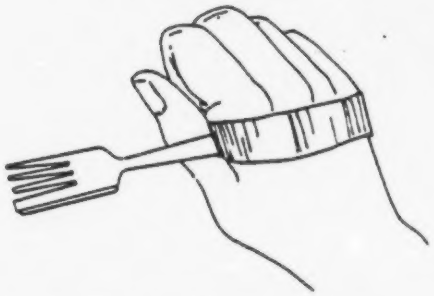
One-third section of disposable pie tin.



Attach to plate by paper clamps.

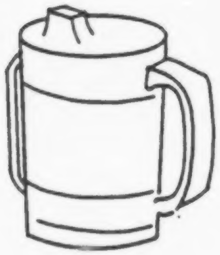


Spilling food is prevented. The rim provides a surface to assist in filling the fork or spoon.

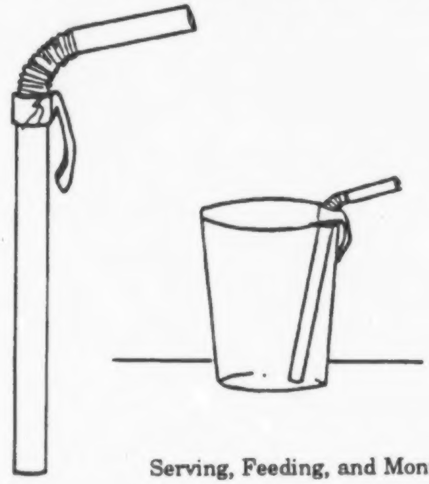


Measure 3/4" elastic to fit snugly around the hand. Stitch a 3" section of soft leather to the elastic - making a snug pocket. Leave one end open. Insert fork or spoon in open end.

DRINKING CUP

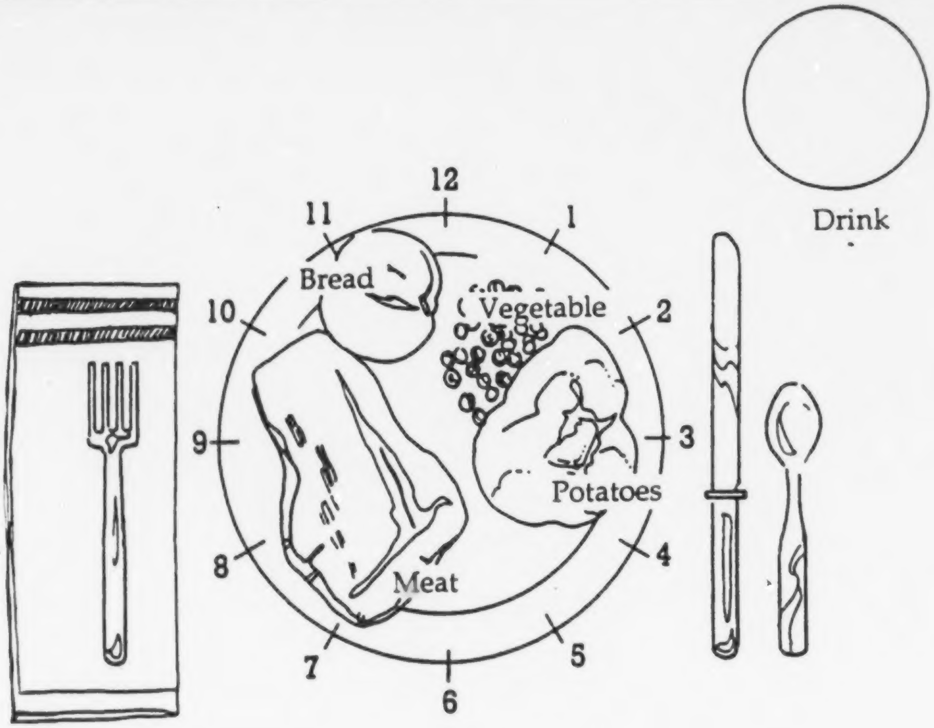


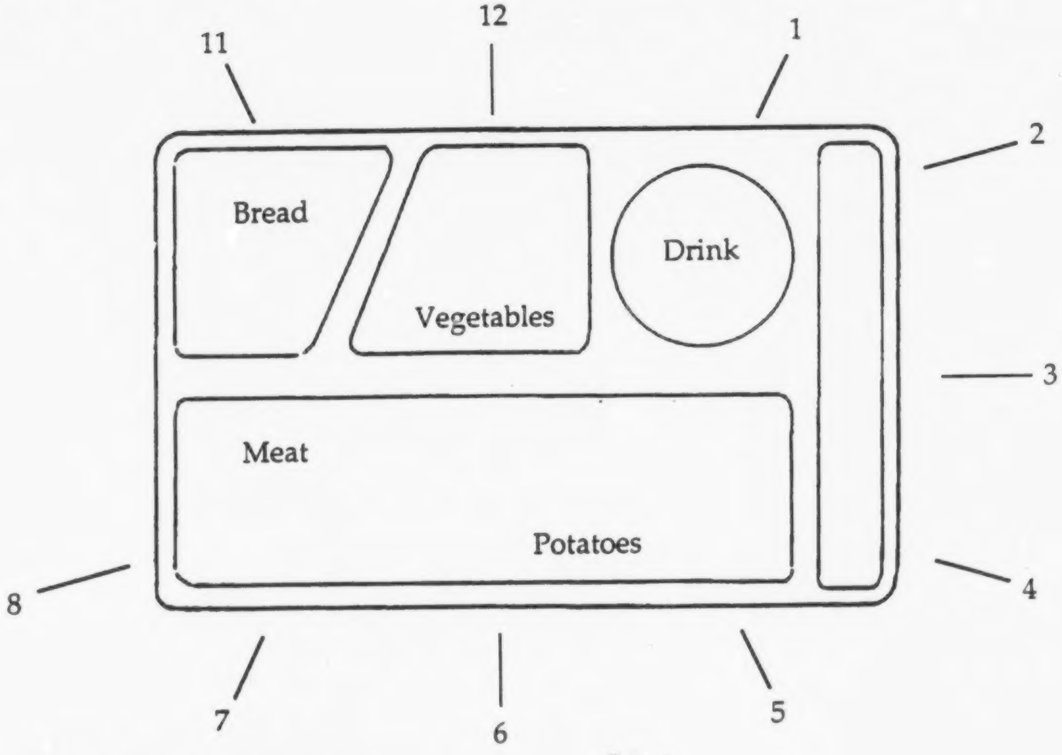
PENCIL CLIP TO FASTEN STRAW TO GLASS



HO 2

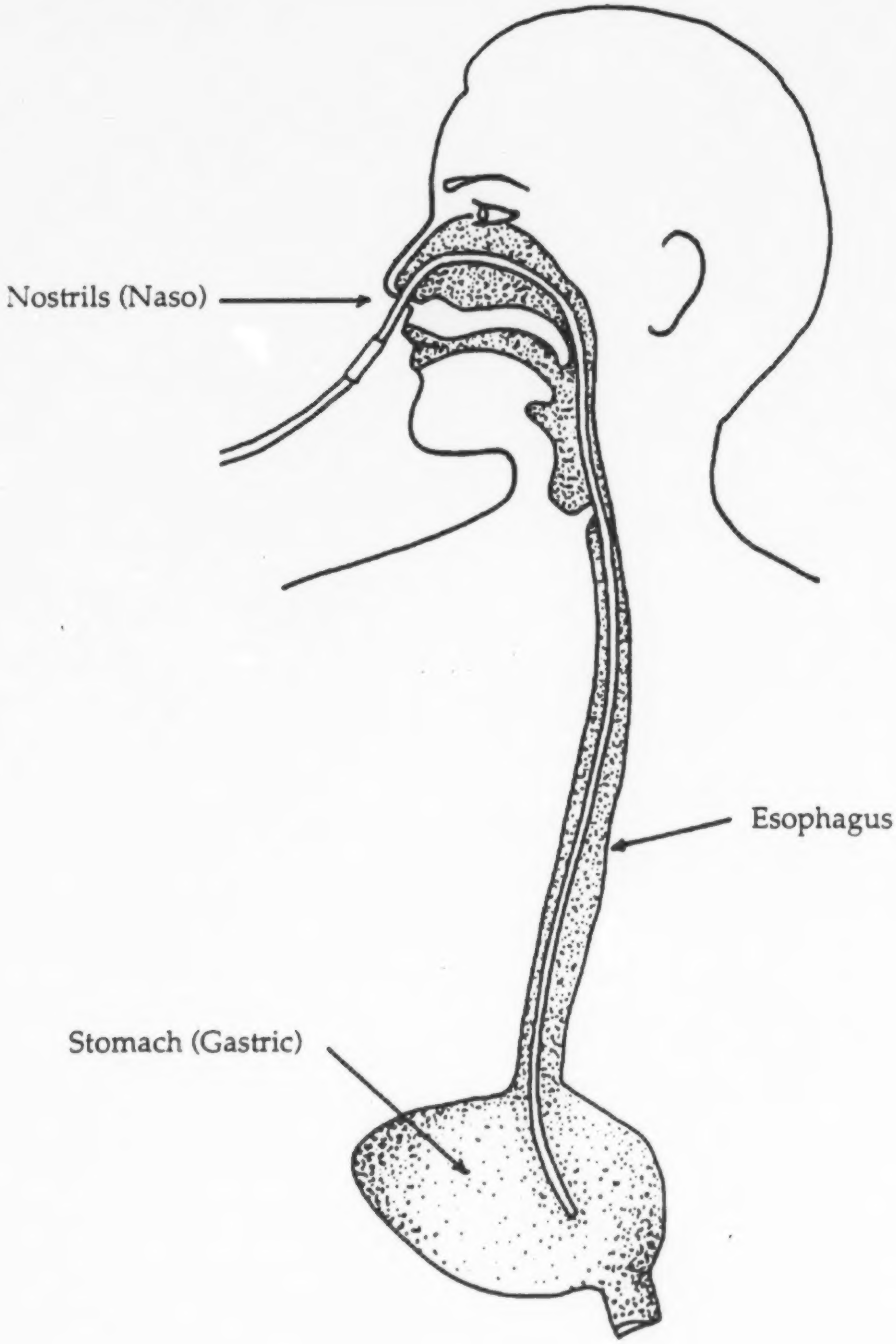
FOOD TRAY FOR THE BLIND CLIENT


12
1
2
3
4
5
6
7
8
9
10
11
Bread
Vegetable
Potatoes
Meat
Drink


11
12
1
2
3
4
5
6
7
8
Bread
Vegetables
Drink
Meat
Potatoes

NASOGASTRIC TUBE

NASOGASTRIC TUBES (Stomach Tubes)


Nostrils (Naso)
Esophagus
Stomach (Gastric)

LESSON PLAN: 34

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-34 OR DEMONSTRATION:

SYSTEMS OF MEASUREMENTS

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify U.S. customary/household system of measurements.
2. Identify metric units of measurements.
3. Identify apothecary units of measurements.
4. Write ten (10) arabic numbers as roman numerals.
5. Convert common U.S. customary/household measurements to metric and apothecary systems.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Metric Table of Units
2. HO 2: Equivalent Measures
3. HO 3: Calculating Measurement Conversions

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 34 (Student Reference page 527) prior to class and be prepared to discuss the information.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Woodrow, Ruth; Essentials of Pharmacology for Health Occupations, 2nd ed. Albany, New York: Delmar Publishers, Inc., 1992.

Medication Technician. University of Missouri-Columbia: Instructional Materials Laboratory, 1986.

INTRODUCTION:

Because the health care system extends over the entire world, it is important for the health care assistant to understand the systems of measurements.

There are three systems of measurements: apothecary, metric, and household system. The apothecary system was the original system of weights and measures. However, the metric system is the preferred system of measurement in health care settings at the present time. The household system is the one which you are probably the most familiar with and the one used when individuals take medications in the home.

It will be important for you to recognize the symbols and abbreviations of the three systems and be able to convert from one system to another. In this lesson, you will study these three systems of measurements as they relate to health occupations.

LESSON PLAN: 34
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT VII: UTILIZING COMMUNICATION AND OBSERVATION SKILLS

OUTLINE:

I. U.S. Customary Units of Measurement - Household System (II-1)
    A. Volume or liquid measurement
        1. Drop - qtt
        2. Teaspoon - tsp
        3. Tablespoon - Tbsp
        4. Ounce - ℥ , oz or oz.
        5. Cup
        6. Pint - pt.
        7. Quart - qt, or qt.
        8. Gallon - gal.
    B. Weight
        1. Ounce - ℥ , oz or oz.
        2. Pound - lb.
    C. Length
        1. Inch - in
        2. Foot - ft
        3. Yard - yd

D. To convert inches to feet; 12 inches = 1 foot

Example:

$$\begin{array}{r|l} & \text{5 ft 6 in} \\ \cline{2-2} \text{12 in} & \text{66 in (height of individual)} \\ \text{(one foot)} & \underline{60}\ (5 \times 12 = 60) \\ & \text{6 inches} \end{array}$$

II. Metric Units of Measurement (II-2)

A. Invented by the French in the late eighteenth century.

B. The metric system is the international standard for weights and measures.

C. Volume or liquid measurements

1. Milliliter - ml
2. Cubic centimeter - cc
3. Liter - l

D. Abbreviations and symbols for the metric system

1. Cubic centimeter - cc
2. Liter - l
3. Milliliter - ml
4. Kilogram - kg
5. Centimeter - cm
6. Gram - gm

E. Solid weight measurements

1. Gram - gm
2. Milligram - mg
3. Kilogram - kg

F. Length

1. Meter - m

2. Centimeter - cm

3. Kilometer - km

III. Apothecary System (II-3)

A. The original system of weights and measures

B. Volume or liquid measurements

1. Minim - m, min

2. Fluid dram - dr, ʒ

3. Fluid ounce - oz, ℥

4. Pint - pt.

5. Quart - qt.

6. Gallon - gal.

C. Solid weight measurements

1. Grain - gr.

2. Dram - dr, ʒ

3. Ounce - oz, ℥

4. Pound - lb.

D. Rules for writing in the apothecary system

1. Lowercase roman numerals are used and follow the unit of measurement (e.g., grv means 5 grains; ℥iii means three ounces)

2. The symbol ss may be used for one-half (e.g., gr iss means 1 1/2 grains; gr viss means 6 1/2 grains)

3. All other fractions are written with arabic numbers and may precede the unit of measurement (e.g., 1/150 gr. or 3 1/4 gr.)

E. Abbreviations and symbols for the apothecary system

1. Grain - gr

2. Minim - m, min

3. Drop - gtt

4. Drops - gtts
5. Dram - dr, ʒ
6. Ounce - oz, ℥
7. Pint - pt.
8. Quart - qt., qt

IV. Roman Numerals/Arabic Number Table (II-4)

A. ARABIC	ROMAN
1	I
2	II
3	III
4	IV
5	V
6	VI
7	VII
8	VIII
9	IX
10	X
20	XX
30	XXX
40	XL
50	L
60	LX
70	LXX
80	LXXX
90	XC

100	C
150	CL

B. Rules for reading roman numerals

1. A repeated letter repeats the value.

   Ex. III = 3

2. A letter occurring after one of greater value is added thereto.

   Ex. VI = 6

3. A letter occurring before one of greater value is subtracted therefrom.

   Ex. IV = 4

V. Measurement Equivalents (II-5)

A. Liquid

US Customary/Household	Apothecaries'	Metric
1 drop (approx.)	1 minim	0.060 milliliter
15 drops (approx.)	15 minims	1 milliliter (1 cubic centimeter)
1 teaspoon (tsp.)	1 fluid dram	5 milliliters (5 cc)
1 dessert spoon	2 fluid drams	10 milliliters (10 cc)
6 tsp/2 Tbsp/1 oz.	1 fluid ounce	30 milliliters (30 cc)
4 oz/juice glass	4 fluid ounces	120 milliliters (120 cc)
16 Tbsp/8 oz/1 Cup	8 fluid ounces	240 milliliters (240 cc)
2 cups/1 pint	1 pint (16 ounces)	500 milliliters (500 cc)
4 c/2 pt/1 quart	1 quart/2 pts. (32 ounces)	1000 milliliters (1000 cc)

B. Dry

1/2 tsp.	30 gr.	2000 mg/2 gm
1/4 tsp.	15 gr.	1000 mg/1.0 gm
1/6 tsp.	10 gr.	600 mg/0.6 gm
1/8 tsp.	7 1/2 gr.	500 mg/0.5 gm
	5 gr.	300 mg/0.3 gm
	4 gr.	250 mg/0.25 gm
	3 gr.	200 mg/0.2 gm
	2 1/2 gr.	150 mg/0.15 gm
	2 gr.	120 mg/0.12 gm
	1 1/2 gr.	100 mg/0.10 gm
	1 gr.	60 mg/0.06 gm
	3/4 gr.	50 mg/0.05 gm
	1/2 gr.	30 mg/0.03 gm
	1/4 gr.	15 mg/0.015 gm
	1/6 gr.	10 mg/0.010 gm

VI. Summary and Conclusion

A. U.S. Customary units of measurement

B. Metric units of measurement

C. Apothecary system

D. Roman numeral/arabic table

E. Measurement equivalents

The next lesson is on observing, measuring, and recording fluid intake and output.

LESSON PLAN: 34

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

INTERACTION ITEMS:

1. What are the units of measurement in the U.S. Customary System?
2. What are the Metric units of measurement for length, weight, and volume?
3. What are the units of measurements in the apothecary system?
4. How do you change arabic numbers to roman numerals?
5. How many cubic centimeters are in 1 teaspoon?
6. How many ounces are in 30 cubic centimeters?
7. How many cubic centimeters are in 8 ounces?
8. How many ounces are in 300 cubic centimeters?
9. How many grams are in 30 grains?
10. How many milliliters are in 1 quart?
11. How many cubic centimeters are in 4 ounces?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Practice converting U.S. Customary measurements to Metric measurements.
2. Have students complete HO 3: "Calculating Measurement Conversions."

ANSWERS TO EVALUATION ITEMS:

1. c
2. a
3. b
4. c
5. b
6. a
7. c
8. b
9. a

10. c
11. e
12. c
13. g
14. a
15. d
16. f
17. V
18. X
19. II
20. VII
21. I
22. VIII
23. III
24. IX
25. IV
26. VI
27. 5 cc
28. 1 oz
29. 240 cc
30. 10 oz
31. 2 Gm
32. 1000 milliliters
33. 120

ANSWERS TO ASSIGNMENT SHEET 1: CALCULATING MEASUREMENT CONVERSIONS

1. 4
2. 450
3. 5 1/2 ft. or 5'6"
4. 120
   90
   60
   270
5. 4
6. 4
7. 4
8. 420
9. 500
10. .03
11. 250
12. .1
13. 2
14. 7.5
15. 36.4
16. 30
17. 4

LESSON PLAN: 34

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : UTILIZING COMMUNICATION AND OBSERVATION SKILLS

EVALUATION ITEMS:

Match the measurement in Column I to the correct system in Column II. A, B, and C may be used more than one time.

Column I

____ 1. Grain
____ 2. Teaspoon
____ 3. Milliliter
____ 4. Fluid ounce
____ 5. Milligram
____ 6. Tablespoon
____ 7. Dram
____ 8. Cubic centimeter
____ 9. Drop
____ 10. Minim

Column II

A. U.S. Customary/Household System
B. Metric System
C. Apothecary System

Match the term of measurement in Column I with the correct abbreviation or symbol in Column II.

Column I		Column II	
___ 11.	Gram	A.	cc
___ 12.	Grain	B.	Cn
___ 13.	Ounce	C.	gr
___ 14.	Cubic centimeters	D.	mg
___ 15.	Milligram	E.	gm
___ 16.	Dram	F.	dr, ʒ
		G.	oz, ℥

Write the following as roman numerals.

17. 5 ___
18. 10 ___
19. 2 ___
20. 7 ___
21. 1 ___
22. 8 ___
23. 3 ___
24. 9 ___
25. 4 ___
26. 6 ___

Convert the following.

27. 1 tsp = ________ cc

28. 30 cc = ________ oz

29. 8 oz = ________ cc

30. 300 cc = ________ oz

31. 30 grains = ________ gram

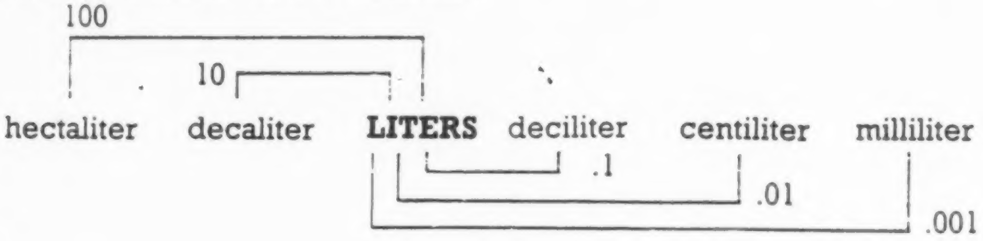
32. 1 quart = ________ milliliters

33. 4 ounces = ________ cubic centimeter

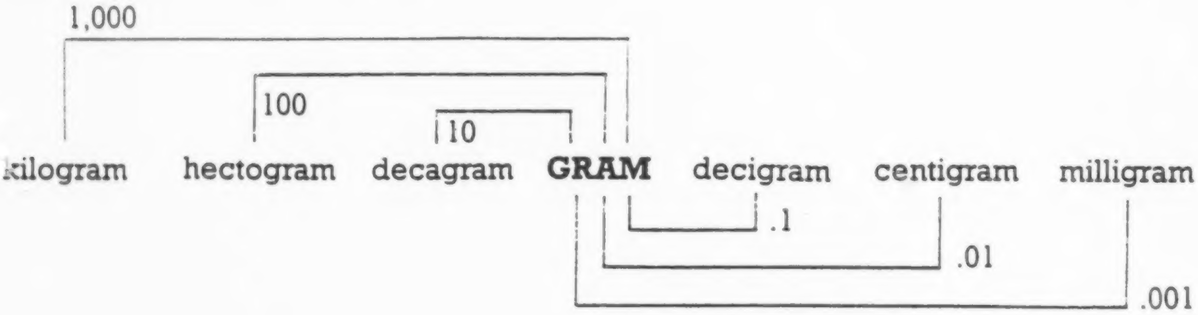
HO 1

METRIC TABLE OF UNITS

VOLUME - BASIC UNIT IS LITER


100
10
hectaliter
decaliter
LITERS
deciliter
centiliter
milliliter
.1
.01
.001

WEIGHT - BASIC UNIT IS GRAM


1,000
100
10
kilogram
hectogram
decagram
GRAM
decigram
centigram
milligram
.1
.01
.001

1. If the decimal point is moved to the right, the value is multiplied by 10.
   0.1 x 10 = 1.0

   To convert from a larger measure to a smaller measure, multiply.

   To convert 5 l to ml, multiply 5 l by 1000 since milliliter is three places to the right of liter.
   5 l x 1000 = 5000 ml

   To convert 2 gm to mg, multiply 2 gm by 1000 since milligram is three places to the right of gram. 2 gm x 1000 = 2000 mg

2. If the decimal point is moved to the left, the value is divided by 10.
   1.0 ÷ 10 = 0.1

   To convert from a smaller measure to a larger measure, divide.

   To convert 100 mg to gm, divide by 1000 since gm is three places to the left of mg.
   100 mg ÷ 1000 = 0.1 gm

   To convert 2500 ml to liters, divide by 1000 since liters are three places to the left of ml. 2500 ml ÷ 1000 = 2.5 l

HO 2

EQUIVALENT MEASURES

Metric		US Customary - Household
1 ml	=	15 minims - 15 drops
5 ml	=	1 tsp
15 ml	=	1 Tbsp.
30 ml	=	1 fluid ounce
500 ml	=	1 pint
1000 ml	=	1 quart
60 mg	=	1 grain
1 Gm	=	15 grains
1000 Gm (1 Kg)	=	2.2 lb

HO 3

CALCULATING MEASUREMENT CONVERSIONS

1. 120 ml = ____ fluid ounces
2. 15 oz = ____ ml
3. Carrie Smith is 66 inches tall. How many feet tall is he?
4. Calculate the following. Convert to cubic centimeters.

    2/3 6 oz glass = ____ cc
    1/4 of 12 oz broth = ____ cc
    1/2 of 4 oz jello = ____ cc
    ______ Total cc

5. Two ounces = ____ tablespoons
6. ____ cups = 1 qt
7. ____ qts = 1 gallon
8. 14 oz = ____ ml
9. 0.5 liter = ____ ml
10. 30 mg = ____ Gm
11. 0.25 liters = ____ ml
12. 100 mg = ____ Gm
13. 30 grains = ____ Gm
14. 450 mg = ____ gr
15. 80 lb = ____ Kg
16. 2 Tbsp. = ____ ml
17. 60 minims = ____ ml

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-35 AND DEMONSTRATION: VII-35

OBSERVE, MEASURE, AND RECORD FLUID INTAKE AND OUTPUT
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Define terms presented in this lesson.
2. List three routes to administer fluids.
3. Identify key points in measuring intake and output.
4. List four fluids which must be measured for oral intake.
5. Transfer household measurement equivalents to cubic centimeters.
6. Define what is meant by the term "frequent fluids."
7. Identify four methods of administering frequent fluids.
8. Convert liquid measurements in ounces to cubic centimeters (milliliters).

Demonstration

9. Distribute drinking water according to the steps of procedure.
10. Measure fluid intake according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Graduate Measures
2. HO 2: Measuring and Recording Fluid Intake and Output
3. HO 3: Fluid Intake and Output Record
4. Graduate measure
5. Intake and output sheet
6. Ice
7. Pitchers
8. Trays
9. Cart
10. Glasses
11. Water
12. Soup bowl
13. Coffee cup
14. Water carafe
15. Foam cup

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 35 (Student Reference page 541) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 20.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 24.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 10.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 9.

Sorrentino, Sheila A. Textbook for Nursing Assistants, 3rd ed. St. Louis, MO: Mosby-Year Book, Inc., 1992.

INTRODUCTION:

A doctor may write an order to encourage fluids, restrict fluids, or nothing by mouth. When the order is to encourage fluids, the client is given an increased amount of fluids. An order for restricted fluids means fluids are restricted to a specific amount. An order of nothing by mouth (NPO) means the client can have nothing to eat or drink.

Since the human body is 60 percent water, this liquid is absolutely essential to life. As a health care assistant, one of your responsibilities may be to make sure your clients have enough fluids. In order to help you meet the needs of your clients, we will be discussing what to observe and how to measure and record the intake and output of fluids for your clients. A normal, healthy person will take in 2,000 to 3,000 cc per day. We eliminate fluids as perspiration (450-1,050 cc/day), through breathing (250-500 cc/day), through feces (50-200 cc/day), and as urine (1,500 cc/day). Most adults will need to consume an average of 600-800 cc of fluids during an eight-hour shift. Many clients sleep during the night shift so additional fluids must be consumed during the day and evening shifts.

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

  A. Diaphoresis - excessive sweating

  B. Graduate - a container marked with lines for measuring liquids (HO 1)

  C. Milliliter (ml) - same as cubic centimeter (cc)

II. Routes to Administer Fluids **(II-2)**

  A. Oral

  B. Intravenous (IV) - into the vein

  C. Nasogastric (NG) tube or gastrostomy (G) tube - into the stomach

III. Measurement of Intake and Output - Key Points

  A. Average oral intake for an adult is 2,500 to 3,000 cc of fluid per day, which is approximately 2 to 3 quarts. Total body output should be about the same. **(II-3)**

  B. Physician or charge nurse may restrict or encourage fluid intake; it is the charge nurse's responsibility to know which has been ordered and to pass this information on to the health care assistant.

  C. When "intake and output" (I&O) is ordered, accuracy is very important and the client and his/her family should be informed of the procedure. (HOs 2 & 3)

  D. Paper and a pencil are kept to record fluid intake for each eight-hour shift.

  E. Checking and recording liquid intake at mealtime and between meals is a nursing responsibility.

  F. Intake and output are totalled and recorded at the end of each shift and at the end of the 24-hour period. **(II-4)**

  G. At mealtime, check client's tray before serving and after client has eaten to determine intake of liquids. Remember that foods which turn liquid if allowed to stand at room temperature are also counted.

H. Before emptying the water pitcher, measure water that is left to determine the amount that has been taken.

I. Observe client for signs of dehydration or edema.

J. Measure urinary output accurately each time bedpan, urinal, specimen container, drainage bag, or bedside commode are emptied, using an accurate graduate. Caution the client to not put toilet paper into the receptacle.

K. Measure and record any other body discharges such as vomitus, diarrhea, or fluid in suction apparatus and drainage on dressings; mention diaphoresis on I&O record if client perspires profusely.

NOTE: If unable to measure accurately, estimate amount and record estimated amount on chart.

L. Measure fluids in a rigid container. Since catheter bags are not always accurate, drain into a graduate then observe and record output.

M. When looking at a transparent graduate, read it at eye level.

N. If the client is incontinent, record the amount and number of times on the I&O sheet.

IV. Fluids Which Must be Measured for Oral Intake (II-5)

A. Water, coffee, tea, broth, ice chips, and gelatin

B. Juices and carbonated beverages (soda)

C. Ice cream, milk shakes, sherbet, milk, and cream

V. Measurement Equivalents from Household to Cubic Centimeters (cc) (II-6)

A. 1 ml = 1 cc

B. 1 tsp = 5 cc

C. 1 oz = 30 cc

D. 1 pt = 500 cc

E. 1 qt = 1,000 cc

NOTE: Most water pitchers contain 1 quart or 1,000 cc.

F. 1 cup (8 oz) = 240 cc

1. If 1 oz = 30 cc then 8 oz would = 240 cc

2. Can be applied to any amount

VI. Frequent Fluids **(II-7)**

A. Means taking in more than the usual number of drinks; offer fluids frequently

B. Elderly may drink less because:

1. Fluid not being readily available or placed within reach
2. Afraid of dribbling urine
3. Afraid of having to get up and go to bathroom at night
4. Difficulty holding a glass, pouring liquid from pitcher, etc.

VII. How to Administer Frequent Fluids **(II-8)**

A. Place fluids within reach.

B. Offer small amounts frequently.

C. Offer a variety of fluids.

D. Encourage foods with high fluid content (pudding, watermelon).

E. Offer favorite beverages.

F. Offer fluids at frequent intervals when client is unable to obtain fluids by himself/herself.

G. If goal has been set, assist client to reach it during time set.

H. Explain that dribbling sometimes results from concentrated urine, infection, or irritation. Therefore, more fluids are needed.

I. Check client during night and assist to bathroom as needed; provide a night light.

J. Distribute drinking water (unless directed otherwise) to assure that fresh water is at the bedside of the client at all times.

1. Offer water at regular intervals and at meals.
2. In long-term care facilities, drinking glasses and pitchers are collected daily and sent to the dietary department where they are sanitized through a dish washing process. In acute care facilities, water pitchers are filled in the clean utility room.

3. Various sized containers are used in facilities. Health care assistants must learn the fluid content of the containers used at the facility where they are employed.

4. Common container sizes **(II-9)**

a.	Coffee/tea cup	8 oz, 240 cc, 240 ml
b.	Water carafe	16 oz, 480 cc, 480 ml
c.	Foam cup	8 oz, 240 cc, 240 ml
d.	Water glass	8 oz, 240 cc, 240 ml
e.	Soup bowl	6 oz, 180 cc, 180 ml
f.	Juice glass	4 oz, 120 cc, 120 ml
g.	Jello, 1 serving	4 oz, 120 cc, 120 ml
h.	Ice chips	2 Tbsp.., 30 cc, 30 ml

VIII. Demonstrate Procedures for Distributing Drinking Water and Measuring Fluid Intake.

IX. Summary and Conclusion

A. Terms and definitions

B. Routes to administer fluids

C. Measurement of intake and output - key points

D. Fluids which must be measured for oral intake

E. Measurement equivalents from household to cubic centimeters

F. Frequent fluids

G. How to administer frequent fluids

H. Review the procedures for distributing drinking water and measuring fluids intake.

This lesson has shown you the importance of fluids and has prepared you to identify those fluids that must be recorded as intake and output. You should now be ready to accurately identify and measure fluids. The next lesson is on oral hygiene.

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

STEPS OF PROCEDURE FOR DISTRIBUTING DRINKING WATER:

1. Wash your hands.
2. Check with charge nurse to identify which clients are not allowed water.
3. Check care plan to identify the clients who do not want or are not allowed ice.
4. Collect pitchers, glasses, and trays from bedside of clients and place on cart or tray.
5. Take cart or tray of equipment to dietary department or clean utility room.
6. Obtain clean pitchers and glasses.
7. For clients allowed ice, fill pitchers 1/3 full with ice; use ice tongs or a large spoon to handle ice.
8. Add water to fill pitchers.
9. Return pitchers promptly to clients' bedside tables.

STEPS OF PROCEDURE FOR MEASURING FLUID INTAKE:

1. Obtain a list of the most commonly used fluid containers in your facility.
2. Wash your hands.
3. Identify client.
4. Explain to client how he/she can assist by writing down the amount and kind of fluids taken (if client is able to d[illegible]).
5. Have form for recording intake and output available.
6. Measure and record all fluids consumed by the client during your shift.
    a. Record intake after each meal before the tray is removed.
    b. Record other intake as it is consumed.
7. Wash your hands.

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What do diaphoresis, graduate and milliliter mean?
2. What are the three (3) routes by which fluids are administered?
3. How many cc of oral fluids should the average adult take in each day?
4. When should the health care assistant total intake and output?
5. What fluids must be measured as oral intake?
6. How many cc are in a teaspoon, 1 ounce, 1 pint, 1 quart, and 1 cup?
7. What is meant by the term frequent fluids?
8. What methods are used to administer frequent fluids?
9. How many cubic centimeters are in a cup, water carafe, foam cup, water glass, soup bowl, and ice chips?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Demonstrate how to read a graduate; have all students read various amounts of fluids.
2. Have students fill out an I&O sheet using HO 2 and HO 3.
3. Have students convert 6 ounces to cc.
4. Have a class discussion on the signs of dehydration and edema.
5. Have students distribute drinking water.
6. The instructor should demonstrate measuring fluid intake.
7. Have students measure fluid intake.

ANSWERS TO EVALUATION ITEMS:

1. c

2. b
3. d

4. a. Oral
   b. Intravenous (IV)
   c. Nasogastric (NG) tube or gastrostomy (G) tube

5. a
6. d
7. c
8. c
9. a
10. 1
11. 5
12. 1
13. 120
14. 240
15. b
16. c

17. 120 cc
    120 cc
    120 cc
    240 cc
    120 cc
    240 cc
    120 cc
    180 cc
    120 cc
    240 cc
    120 cc
    Total 1,740 cc

18. c
19. d
20. c
21. a

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

1. What is diaphoresis? (Circle the letter of the best answer.)

   a. Excessive vomiting
   b. Excessive diarrhea
   c. Excessive sweating
   d. Excessive thirst

2. What is a graduate? (Circle the letter of the best answer.)

   a. A syringe marked with lines for measuring
   b. A container marked with lines for measuring liquids
   c. A bag marked with lines for measuring solids
   d. A medicine glass marked with lines for measuring liquids

3. A milliliter is the same as a: (Circle the letter of the best answer.)

   a. Gram.
   b. Grain.
   c. Milligram.
   d. Cubic centimeter.

4. The three routes to administer fluids are:

   a.

   b.

   c.

5. What is the average oral intake of fluids per day for an adult? (Circle the letter of the best answer.)

   a. 2,500 cc to 3000 cc
   b. 1,500 cc to 2,000 cc
   c. 1,500 cc to 1,000 cc
   d. 4,000 cc to 5,000 cc

6. How often are intake and output totalled? (Circle the letter of the best answer.)

   a. Every four hours and at the end of each 8-hour shift
   b. Every time fluids are taken
   c. At the end of the evening shift
   d. At the end of each shift and at the end of a 24-hour period

7. When recording fluid intake on the intake and output sheet, you should record an amount that: (Circle the letter of the best answer.)

   a. You remember.
   b. The client tells you.
   c. Is accurate.
   d. Is an estimate.

8. Your assigned client is on intake and output. The client: (Circle the letter of the best answer.)

   a. Can urinate directly into the toilet stool.
   b. Can put toilet paper into the bedpan.
   c. Must use the bedpan, urinal, commode, or specimen container.
   d. Needs to tell you the amount he/she urinated.

9. Which one of the following is not counted on the fluid intake? (Circle the letter of the best answer.)

   a. Rice
   b. Gelatin
   c. Milk shake
   d. Orange juice

Fill in the blanks.

10. 1 ml = ___ cc

11. 1 tsp = ___ cc

12. ___ oz = 30 cc

13. 4 oz = ___ cc

14. 8 oz water glass = ___ cc

15. What is meant by frequent fluids? (Circle the letter of the best answer.)

   a. Forcing the client to drink
   b. Offering fluids frequently to exceed the usual number of drinks taken
   c. Restriction of solid foods so as to increase water intake
   d. Administration of intravenous fluids

16. When administering frequent fluids the health care assistant should: (Circle the letter of the best answer.)

    a. Offer large amounts of fluids with meals.
    b. Offer only water as the fluid.
    c. Offer small amounts of a variety of fluids frequently.
    d. Discourage foods such as pudding and watermelon.

17. During your shift, a client whom you are assigned to consumed the following liquids. Determine the total intake.

7:30 a.m.	1/2 glass water	______________ cc
8:15 a.m.	1/2 glass orange juice	
	1 cup coffee	
	1 glass milk	______________ cc
9-10 a.m.	Sips of water about 1/2 glass	______________ cc
10:30 a.m.	1 glass grape juice	______________ cc
12:00 noon	1 jello	
	1 bowl soup	
	1/2 glass milk	______________ cc
1:45 p.m.	1 glass water	______________ cc
2:30 p.m.	1/2 foam cup prune juice	______________ cc
	TOTAL	______________ cc

18. Your assigned client has the following amounts of intake recorded as shift totals: 400 cc; 500 cc; and 450 cc. What is the total intake for the day? (Circle the letter of the best answer.)

    a. 950 cc
    b. 1,250 cc
    c. 1,350 cc
    d. 2,300 cc

19. If a water glass holds 240 cc and the client drank four glasses of water during your shift, what would be the correct amount of oral fluids to record on the intake/output sheet? (Circle the letter of the best answer.)

    a. 830 cc
    b. 480 cc
    c. 720 cc
    d. 960 cc

20. Your client took in 180 ml of soup and 120 ml of juice. This intake would be the same as: (Circle the letter of the best answer.)

    a. 6 ounces
    b. 430 ml
    c. 10 ounces
    d. 450 ml

21. If urine output is 15 ounces, you might record it as: (Circle the letter of the best answer.)

a. 380 cc
b. 480 cc
c. 450 ml
d. 300 ml

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

DISTRIBUTE DRINKING WATER

EQUIPMENT:

1. Pitchers
2. Glasses
3. Trays
4. Cart
5. Water
6. Ice
7. Ice tongs or large spoon

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Check with charge nurse to identify which clients are not allowed water.		
3. Check care plan to identify the clients who do not want or are not allowed ice.		
4. Collect pitchers, glasses, and trays from bedside of clients and place on cart or tray.		
5. Take cart or tray of equipment to dietary department or clean utility room.		
6. Obtain clean pitchers and glasses.		
7. For clients allowed ice, fill pitchers 1/3 full with ice; use ice tongs or a large spoon to handle ice.		
8. Add water to fill pitchers.		
9. Return pitchers promptly to clients' bedside tables.		

The student has satisfactorily completed the procedure "DISTRIBUTE DRINKING WATER" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

LESSON PLAN: 35

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ____________

MEASURE FLUID INTAKE

EQUIPMENT:

1. I&O form
2. Pencil

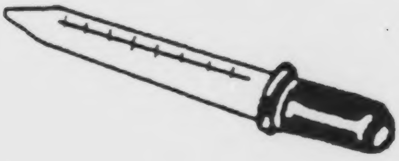
CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Obtain a list of the most commonly used fluid containers in your facility.		
2. Wash your hands.		
3. Identify client.		
4. Explain to client how he/she can assist by writing down the amount and kind of fluids taken (if client is able to do so).		
5. Have form for recording intake and output available.		
6. Measure and record all fluids consumed by the client during your shift. a. Record intake after each meal before the tray is removed.		
b. Record other intake as it is consumed.		
7. Wash your hands.		

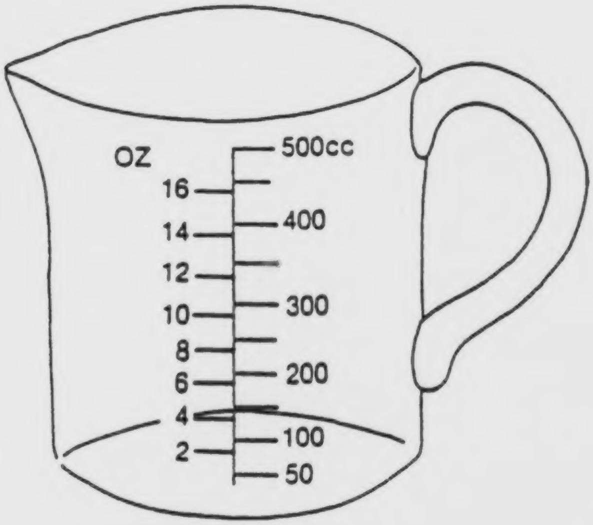
The student has satisfactorily completed the procedure "MEASURE FLUID INTAKE" according to the steps outlined.

____________________ ____________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

GRADUATE MEASURES




OZ
16
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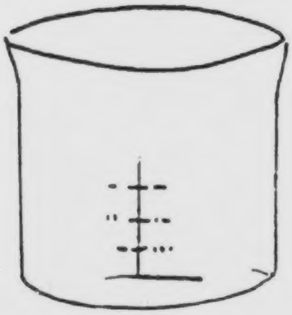

HO 2

MEASURING AND RECORDING FLUID INTAKE AND OUTPUT

Directions: Use the intake and output chart (HO 3). Put the following information in the proper column and total the figures. Compute the intake and output.

A. Date - May 11

B. Name - John Middleman, Jr.

C. South Wing: Room 255

D. Method of Administration: Oral

E.	7:30 a.m.	Urine	500 cc
	8:00 a.m.	Grape juice	90 cc
		Milk	120 cc
		Coffee	90 cc
	9:30 a.m.	Water	180 cc.
	12:00 Noon	Tea	120 cc.
		Soup	180 cc.
	1:00 p.m.	Water	90 cc.
	1:15 p.m.	Urine	300 cc.
	2:00 p.m.	Apple juice	120 cc.
	2:15 p.m.	Vomitus	120 cc.
	3:20 p.m.	Tea	120 cc.
	5:00 p.m.	Orange juice	60 cc.
	5:30 p.m.	Urine	400 cc.
	6:30 p.m.	Water	150 cc.
	8:45 p.m.	Ginger ale	150 cc.
	9:00 p.m.	Urine	300 cc.
	10:00 p.m.	Water	90 cc.
	10:15 p.m.	Urine	200 cc.

HO 3

FLUID INTAKE AND OUTPUT RECORD

MANOR CARE CENTER
FLUID INTAKE and OUTPUT RECORD

Name: Room:

INTAKE					OUTPUT			
Date	Time	Method Admin.	Solution	Amount Received	Time	Urine Amount	Others	
							Kind	Amount
TOTAL					TOTAL			

1 Ounce = 30 cc 8 oz. Glass = 240 cc 4 oz. Juice Glass = 120 cc
*4 oz. Soup Bowl = 120 cc 6 oz. Cup = 180 cc *Jello-4 oz. = 120 cc

*Measure servings in each facility to establish an accurate measure.

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-36 AND DEMONSTRATION: VII-36

ORAL HYGIENE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Define terms presented in this lesson.
2. Identify the purposes of oral hygiene.
3. Identify when clients should have oral hygiene.
4. Identify observations the health care assistant can make while giving oral hygiene.
5. Identify key points in the care of teeth and dentures.

Demonstration

6. Assist with oral hygiene according to the steps of procedure.
7. Administer oral hygiene to the helpless/unconscious client according to the steps of procedure.
8. Provide denture care according to the steps of procedure.
9. Floss teeth

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Oral Care Techniques, video #13, available from the Missouri Vocational Resource Center, 13 min.
2. Television and VCR
3. Cup or glass
4. Emesis basin
5. Water
6. Toothbrush
7. Hand towel
8. Toothpaste, powder, or denture cleanser
9. Mouthwash
10. Denture cup (if applicable)
11. Clean washcloth, towel
12. Tongue depressor
13. Lemon and glycerine swab, toothette, or other mouth care swab
14. Lip balm
15. Nonsterile gloves
16. Dentures
17. Dental floss
18. HO 1: Oral Care

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 36 (Student Reference page 559) and be prepared to discuss the information presented and return the demonstrations of giving oral hygiene to various types of clients according to steps of procedure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 23.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 21.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 6, Section 4.

INTRODUCTION:

Oral hygiene is the cleaning and care of the teeth, gums, and inside surfaces of the mouth. Plaque is a sticky, transparent bacterial film found on the teeth. If plaque is not removed, it will react with sugar from foods eaten to produce an acid and toxins. These can dissolve the outer covering of the teeth causing decay and irritation of the gums. Eventually it can lead to loss of teeth. Good brushing and mouth care can remove the plaque.

Think about how your mouth tastes upon waking up in the morning or by the end of a day. It can definitely affect your appetite and the way you feel. Halitosis can prevent communication from occurring; it is uncomfortable to be around someone who has "bad breath."

Many of the clients cannot carry out this procedure by themselves; others may only need you to prepare everything for them. See that our clients get proper mouth care.

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Caries - tooth decay

   B. Halitosis - bad breath

   C. Oral hygiene - care of the mouth, teeth, and gums

   D. Plaque - sticky, transparent bacterial film found on the teeth

II. Purposes of Oral Hygiene (mouth care) - A clean mouth and properly functioning teeth are essential for physical and mental well-being of the client. (II-2)

   A. Prevent infections in mouth

   B. Remove food particles and plaque

   C. Stimulate circulation of gums

   D. Eliminate bad taste in mouth, thus food is more appetizing

III. When Client Should Have Oral Hygiene (II-3)

   A. After meals and at bedtime

   B. Clients requiring more frequent oral hygiene

      1. The unconscious client requires mouth care every 2 hours.

         a. He/she usually breathes only through the mouth causing secretions to stick on surfaces of the mouth.

         b. Always keep the head turned to the side to allow for secretions to drain from the mouth, preventing them from collecting at the back of his/her throat which could result in choking.

      2. Those who have vomited

      3. Those who have a high temperature

      4. Those who are mouth breathers

5. Those who are dying

6. Those receiving oxygen

7. Those who are dehydrated

IV. Specific Observations to Make (II-4)

A. Tooth decay (blackened), any loose or broken teeth

B. Red or swollen gums

C. Sores or white patches in the mouth or on the tongue

D. Changes in eating habits

NOTE: If client avoids foods that require a lot of chewing it may indicate pain in mouth.

E. Poorly fitting dentures

F. All mouth-care equipment (toothbrush, cup, toothpaste) of the client should be labeled with his/her name to prevent mixing up equipment. This could be a source of spreading infection.

G. Dilute mouthwash since it has such a strong flavor: 1/2 part mouthwash to 1/2 part water. (II-5)

H. Mouthwash does not replace the need to brush teeth; it only makes the mouth taste fresher.

I. Always wash your hands and put on gloves before giving oral hygiene.

V. Key Points of Teeth and Denture Care (II-6)

A. Denture care

1. Handle dentures (false teeth) carefully to prevent damage; they are expensive to replace. Always wear gloves and handle dentures with washcloth or paper towel to prevent them from slipping out of your hand. Store dentures in a denture cup inside the bedside stand when not in use.

2. Keep dentures in water when not in the mouth to prevent warping; never use hot water to clean or store them, it could also cause warping.

3. Soaking dentures in denture solution does not eliminate the need for daily brushing.

4. A washcloth or paper towel is placed in the sink to prevent dentures from breaking should they slip out of your hand.

5. Denture cup should be labeled with client's name.

B. Tips on Brushing Teeth

1. Instruct the client to position the brush horizontally and brush all tooth surfaces back and forth with short strokes.

2. Position the brush at a 45°angle against the inside of the front teeth.

3. Brush from the gum to the crown of the tooth with short strokes.

4. Reposition the brush until all of the front teeth have been brushed.

5. Hold the brush horizontally against the inner surface of the teeth and brush back and forth.

6. Position the brush on the biting surface of the teeth and brush back and forth.

VI. Demonstrate Procedures for Giving Oral Hygiene.

VII. Summary and Conclusion

A. Terms and definitions

B. Purposes of oral hygiene

C. When client should have oral hygiene

D. Specific observations to make

E. Key points of denture care

F. Review procedures for giving oral hygiene.

The next lesson is on elimination of stool.

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

STEPS OF PROCEDURE FOR ASSISTING WITH ORAL HYGIENE:

1. Wash your hands. Put on gloves.
2. Arrange necessary equipment for client.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Dilute mouthwash (1/2 mouthwash to 1/2 water).
7. Assist client to bathroom or upright sitting position.
8. Pour water over toothbrush; instruct or assist client to put a small amount of toothpaste on the toothbrush.
9. Instruct or assist client to brush along gum line, then brush teeth up and down on both sides.
10. Brush the biting surfaces of the molars with a back-and-forth motion.
11. Brush the tongue gently.
12. Instruct or assist client to rinse his/her mouth with water; hold emesis basin under client's chin with one hand.
13. Allow client to spit into emesis basin or sink; wipe lips with towel.
14. Provide client with mouthwash (may use a straw); instruct client to swish around in mouth and spit out, cautioning client not to swallow mouthwash.
15. Allow client to spit into emesis basin or sink; wipe lips with hand towel.
16. Lubricate lips with lip balm.
17. Remove, clean, and store equipment.
18. Remove gloves and dispose in appropriate container.
19. Wash your hands; wash client's hands.

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20. Make client comfortable.

21. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR ORAL HYGIENE FOR HELPLESS OR UNCONSCIOUS CLIENT:

1. Wash your hands. Put on gloves.

2. Arrange necessary equipment for client.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Move the client to the side of the bed nearest you. Turn head to side.

7. Spread towel under client's chin.

8. Moisten washcloth over the emesis basin with diluted mouthwash.

9. Clean teeth and gums. Wrap the wet cloth securely around a tongue depressor or use a commercial mouth swab to clean the tongue and inside surfaces of mouth.

10. Moisten toothbrush with diluted mouthwash. Brush gum line and teeth in up-and-down motion on both sides.

11. Wipe lips with a towel.

12. Apply lip balm to the client's lips.

13. Remove, clean, and store equipment.

14. Remove gloves and dispose in appropriate container.

15. Wash your hands.

16. Make client comfortable.

17. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR PROVIDING DENTURE CARE:

1. Wash your hands. Put on gloves.

2. Arrange necessary equipment for client.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Ask the client to remove dentures or run your finger along the top of the upper gum as you gently push the upper edge of the denture forward and down. Lower dentures can be removed the same way along the lower gum line; push forward and up.

7. Place dentures in clean denture cup.

8. Provide water or diluted mouthwash to rinse the mouth of food particles.

9. Allow client to spit into emesis basin or sink.

10. Have client wipe mouth with towel or tissue.

11. Apply lip balm to lubricate lips.

12. Fill a clean sink 1/2 full of cool water or place a clean washcloth on bottom of sink.

13. Brush dentures thoroughly using toothbrush and denture cleanser.

14. Rinse dentures with cool water and place in a clean cup.

15. If client wants to wear dentures, replace them in mouth (upper plate first).

16. If client is not going to wear dentures, store them in a clean denture cup filled with appropriate solution.

17. Remove, clean, and store equipment.

18. Remove gloves and dispose in appropriate container.

19. Wash your hands; wash client's hands.

20. Make client comfortable.

21. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR FLOSSING TEETH:

1. Wash hands. Put on gloves.

2. Assemble equipment.

3. Break off an 18-inch piece of floss.

4. Hold the floss between the middle finger of each hand.

5. Stretch the floss with your thumbs.
6. Floss from the upper back tooth on the right side and continue to the far left side.
7. Move the floss gently up and down between each tooth.
8. Use a different section of floss after every second tooth.
9. Floss the lower teeth holding the floss with your index fingers.
10. Use back and forth motions.
11. Let the client rinse his/her mouth.
12. Clean and return equipment to its proper place.
13. Remove gloves.
14. Wash hands.

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What are plaque, halitosis, oral hygiene, and carries?

2. What are four purposes of oral hygiene?

3. When should the client have oral hygiene?

4. What five observations of the mouth should the health care assistant make when giving oral hygiene?

5. How is mouthwash diluted?

6. How should dentures be cared for?

7. What can the health care assistant do to protect the client's dentures from breakage when cleaning them?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show video.

2. Instructor demonstrates assisting with oral hygiene.

3. Students practice assisting with oral hygiene. Have students brush each other's teeth.

4. Instructor demonstrates providing oral hygiene to the helpless client.

5. Students practice giving oral hygiene to the helpless client.

6. Instructor demonstrates giving denture care.

7. Students practice giving denture care.

ANSWERS TO EVALUATION ITEMS:

1. d
2. a
3. e
4. c

5. c
6. d
7. b
8. c
9. d
10. b
11. a
12. b

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

		Column I		Column II
____	1.	Carries	a.	Bad breath
____	2.	Halitosis	b.	Mouthwash
____	3.	Plaque	c.	Care of the mouth, teeth, and gums
____	4.	Oral hygiene	d.	Tooth decay
			e.	Sticky, transparent bacterial film found on the teeth

5. Which one is not a purpose of oral hygiene? (Circle the letter of the best answer.)

   a. Prevents infection in the mouth
   b. Stimulates circulation of the gums
   c. Relaxes the client and prevents body odor
   d. Removes food particles and plaque

6. The client who is unconscious should receive mouth care: (Circle the letter of the best answer.)

   a. Two times a day like other clients.
   b. Less frequently than other clients.
   c. Mouth care is not given to the unconscious client.
   d. Every two hours.

7. How often should a person's teeth be brushed? (Circle the letter of the best answer.)

   a. One time a day
   b. After meals and at bed time
   c. First thing in the morning before breakfast
   d. Only when needed

8. What should the health care assistant check for when giving mouth care? (Circle the letter of the best answer.)

a. If the client has his/her wisdom teeth
b. If the teeth shine
c. If there are any loose teeth or poorly fitting dentures
d. The amount of fillings and bridge work

9. Mouthwash: (Circle the letter of the best answer.)

a. Replaces the need to brush teeth.
b. Should be used full streagth.
c. Should not be used if the client has halitosis.
d. Should be diluted, 1/2 mouthwash to 1/2 water.

10. Which one of the following is a true statement about dentures? (Circle the letter of the best answer.)

a. Only the charge nurse handles the client's dentures.
b. When cleaning dentures, place a washcloth or paper towel in the sink to prevent breakage of dentures.
c. Soaking dentures in denture solution eliminates the need for daily brushing.
d. Dentures should be cleaned while in the client's mouth to prevent them from slipping out of your hand.

11. Where should dentures be located when not in use? (Circle the letter of the best answer.)

a. Stored in a denture cup in the drawer of the bedside table.
b. Stored in a cup on top of the bedside table.
c. Stored in a denture cup on the edge of the bathroom sink.
d. Always in the client's mouth.

12. To remove dentures from a client's mouth: (Circle the letter of the best answer.)

a. With gloved hand, remove upper dentures by gently pushing forward and up.
b. With gloved hand, remove upper dentures by gently running your finger along the top of upper gum and pushing edge of denture forward and down.
c. With gloved hand, remove upper dentures by gently running your finger along the gum line and pushing edge of denture downward and up.
d. With gloved hand, always remove the lower dentures before removing the upper dentures.

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:______________

ASSIST WITH ORAL HYGIENE

EQUIPMENT:

1. Cup or glass
2. Emesis basin
3. Water
4. Toothbrush
5. Hand towel
6. Toothpaste or powder
7. Mouthwash
8. Lip balm
9. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Arrange necessary equipment for client.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Dilute mouthwash (1/2 mouthwash to 1/2 water).		
7. Assist client to bathroom or upright sitting position.		
8. Pour water over toothbrush; instruct or assist client to put a small amount of toothpaste on the toothbrush.		
9. Instruct or assist client to brush along gum line; then brush teeth up and down on both sides.		
10. Brush the biting surfaces of the molars with a back-and-forth motion.		
11. Brush the tongue gently.		
12. Instruct or assist client to rinse his/her mouth with water; hold emesis basin under client's chin with one hand.		

13.	Allow client to spit into emesis basin or sink; wipe lips with towel.		
14.	Provide client mouthwash (may use a straw); instruct client to swish around in mouth and spit out, cautioning client not to swallow mouthwash.		
15.	Allow client to spit into emesis basin or sink; wipe lips with hand towel.		
16.	Lubricate lips with lip balm.		
17.	Remove, clean, and store equipment.		
18.	Remove gloves and dispose in appropriate container.		
19.	Wash your hands; wash client's hands.		
19.	Make client comfortable.		
20.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ASSIST WITH ORAL HYGIENE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

703

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

ADMINISTER ORAL HYGIENE TO HELPLESS/UNCONSCIOUS CLIENT

EQUIPMENT:

1. Cup or glass
2. Emesis basin
3. Water
4. Toothbrush
5. Hand towel
6. Toothpaste or powder
7. Mouthwash
8. Lip balm
9. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Arrange necessary equipment for client.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Move the client to the side of the bed nearest you. Turn head to side.		
7. Spread towel under client's chin.		
8. Moisten washcloth over the emesis basin with diluted mouthwash.		
9. Clean teeth and gums. Wrap the wet cloth securely around a tongue depressor or use a commercial mouth swab to clean the tongue and inside surfaces of mouth.		
10. Moisten toothbrush with diluted mouthwash. Brush gum line and teeth in up-and-down motion on both sides.		
11. Wipe lips with a towel.		
12. Apply lip balm to the client's lips.		

13.	Remove, clean, and store equipment.		
14.	Remove gloves and dispose in appropriate container.		
15.	Wash your hands.		
16.	Make client comfortable.		
17.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ADMINISTER ORAL HYGIENE TO HELPLESS/UNCONSCIOUS CLIENT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

705

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT:________________

PROVIDE DENTURE CARE

EQUIPMENT:

1. Cup or glass
2. Emesis basin
3. Water
4. Toothbrush
5. Hand towel
6. Denture cleanser
7. Mouthwash
8. Denture cup
9. Lip balm
10. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Arrange necessary equipment for client.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Ask the client to remove dentures or run your finger along the top of the upper gum as you gently push the upper edge of the denture forward and down. Lower dentures can be removed the same way along the lower gum line; push forward and up.		
7. Place dentures in clean denture cup.		
8. Provide water or diluted mouthwash to rinse the mouth of food and particles.		
9. Allow client to spit into emesis basin or sink.		
10. Have client wipe mouth with towel or tissue.		
11. Apply lip balm to lubricate lips.		
12. Fill a clean sink 1/2 full of cool water or place a clean washcloth on bottom of sink.		

13.	Brush dentures thoroughly using toothbrush and denture cleanser.		
14.	Rinse dentures with cool water and place in a clean cup.		
15.	If client wants to wear dentures, replace them in mouth (upper plate first).		
16.	If client is not going to wear dentures, store them in a clean denture cup filled with appropriate solution.		
17.	Remove, clean, and store equipment.		
18.	Remove gloves and dispose in appropriate container.		
19.	Wash your hands; wash client's hands.		
20.	Make client comfortable.		
21.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "PROVIDE DENTURE CARE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 36

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:______________

FLOSS TEETH

EQUIPMENT:

1. Gloves
2. Dental floss
3. Glass
4. Emesis pan

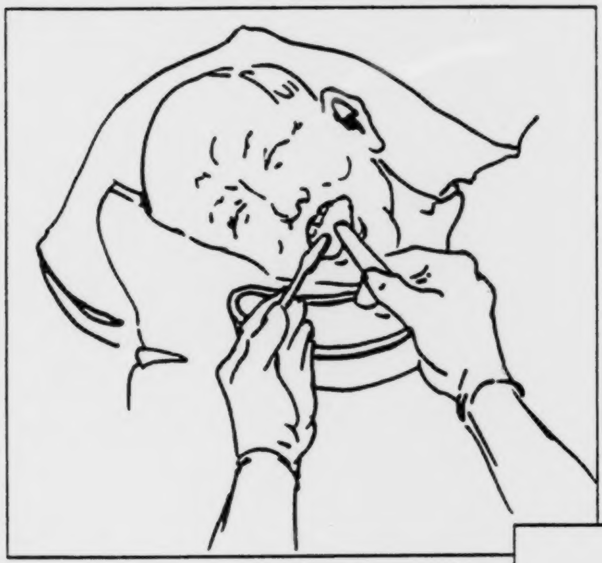
CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. Put on gloves.		
2. Assemble equipment.		
3. Break off an 18-inch piece of floss.		
4. Hold the floss between the middle finger of each hand.		
5. Stretch the floss with your thumbs.		
6. Floss from the upper back tooth on the right side and continue to the far left side.		
7. Move the floss gently up and down between each tooth.		
8. Use a different section of floss after every second tooth.		
9. Floss the lower teeth holding the floss with your index fingers.		
10. Use back and forth motions.		
11. Let the client rinse his/her mouth.		
12. Clean and return equipment to its proper place.		
13. Remove gloves.		
14. Wash hands.		

The student has satisfactorily completed the procedure "FLOSS TEETH" according to the steps outlined.

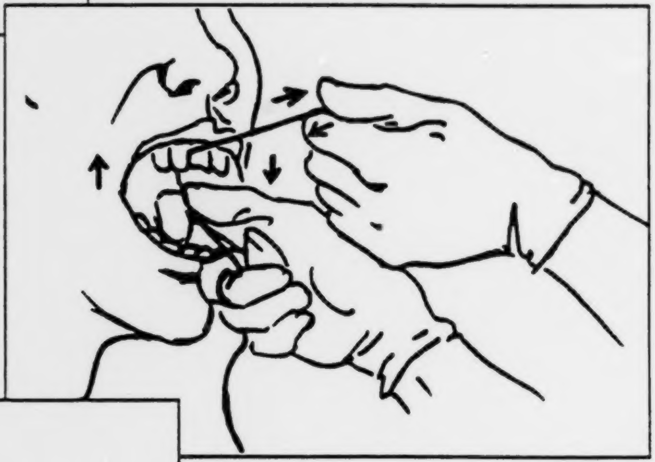
______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion) Date

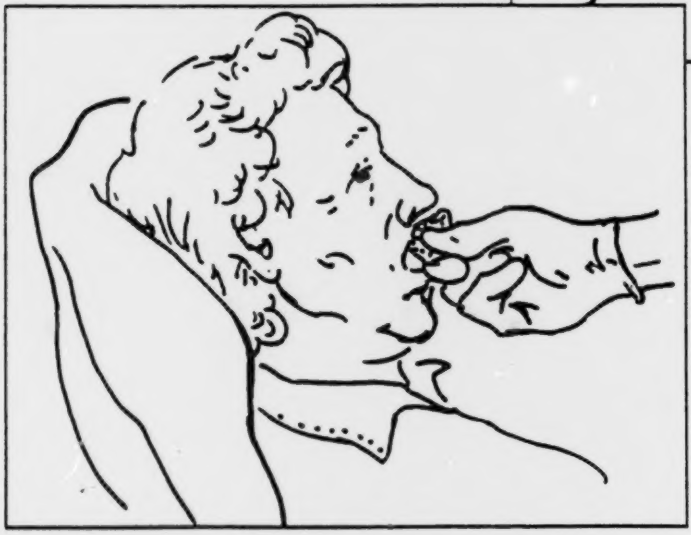
ORAL CARE



Technique for Cleaning the Mouth



Technique for Flossing Teeth



Removing Dentures

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

SCOPE OF UNIT:

This unit covers related terminology, structure, description, function, and diagrams of the digestive system. It also covers basic nutrition; serving, feeding, and monitoring clients; intake of food and fluids; elimination of stool; and oral hygiene. It includes the following procedures: feeding the helpless client, measuring and recording fluid intake and output, measuring height and weight, giving and removing bedpan, giving an unmedicated enema, giving mouth care to the unconscious client, giving oral hygiene, and flossing teeth.

INFORMATION TOPIC: VII-37 AND DEMONSTRATION: VII-37

ELIMINATION OF STOOL
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. Identify four factors that maintain normal bowel function.
3. Describe the characteristics of normal stool.
4. Describe the characteristics of abnormal stool.
5. Identify four conditions that may cause abnormal bowel function.
6. Identify factors that can lead to constipation.
7. Identify two special measures for abnormal bowel function.
8. Identify the position of choice for administering an enema.
9. Identify important points to remember when administering a cleansing enema.

Demonstration

10. Give and remove bedpan.
11. Administer an unmedicated enema according to steps of procedure.

12. Collect stool specimen.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Administering an Enema
2. Enema bag/bucket
3. Enema soap (if applicable)
4. Bedpan and toilet tissue
5. Tap water - 105°F
6. Disposable/reusable bed protector
7. Water-soluble lubricant
8. Bath blanket
9. Paper towels
10. Washcloths
11. Towels
12. Gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 37 (Student Reference page 575) prior to class and be prepared to discuss the information presented and return the demonstration of giving an enema according to procedure.

REFERENCES:

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Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 28.

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Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 9, Section 5 and Chapter 5.

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INTRODUCTION:

Elimination of stool is another one of the body's basic functions. Food is taken in, digested, and whatever is not needed by the body is eliminated as waste through defecation. There are some basic factors that keep our bowels functioning properly. The health care assistant must keep these factors in mind because many elderly clients have problems with their bowels, and often times their long-term habits have been interrupted. Normal bowel function is necessary for the client's comfort.

Some clients cannot eliminate stool in a natural manner and need help. We can provide help by administering enemas. The type of enema will be determined by the instruction received from the charge nurse. There are several types of enemas that can be given. The procedure is basically the same for each type. Never give an enema in a sitting position because the solution cannot flow into the bowel.

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Constipation - the passage of unusually dry, hard stools

   B. Defecation - passing feces from the body

   C. Diarrhea - frequent passage of liquid stool

   D. Distention - the state of being inflated or enlarged

   E. Feces - waste products in the bowel, same as stool or BM

   F. Flatus - gas in the bowel

   G. Impaction - hard stool that cannot pass from the rectum normally

   H. Peristalsis - wave-like movement of the bowels that pushes stool along intestinal tract

   I. Suppository - a semisolid substance that may contain medicine that dissolves when inserted into the rectum or vagina

II. Factors That Maintain Normal Bowel Elimination (II-2)

   A. Diet containing fiber

      1. Fiber holds water in the wastes in the colon, makes the stool softer.

      2. Fibrous foods are slightly irritating to the bowel, move wastes along more rapidly.

      3. Nursing responsibilities - encourage foods high in fiber to help prevent constipation

         a. Fresh fruits

         b. Fresh vegetables

         c. Prunes

         d. Bran

B. Fluids

1. Fluids make the stool softer and increase the bulkiness of the stool.

2. Nursing responsibilities

a. Provide between 2,500-3,000 ml of fluids per 24 hours.

b. Maintain I&O record.

C. Activity

1. Physical activity produces a "massaging" action of the abdominal muscles to the intestines, promoting peristalsis.

2. Nursing responsibilities

a. Encourage ambulation, if possible.

b. If client is on bed rest or confined to a W/C, encourage active ADL, ROM, and position change every two hours.

D. Habit

1. Each individual defecates at a certain time of day, sometimes more easily after eating or drinking certain foods or fluids.

2. Usually has more success if privacy is offered

3. Nursing responsibilities

a. Find out from client or family member past bowel habits: how often, time of day, any routine assistance from suppositories/ enemas-/medications.

b. Provide privacy and try to maintain past habits.

III. Characteristics of Normal Stool **(II-3)**

A. Color - light to dark brown

B. Consistency - soft and formed

C. Frequency - 3 times/day to every other day; varies with each individual

IV. Characteristics of Abnormal Stool **(II-4)**

A. Smells unusual

B. Is not dark brown

C. Contains undigested food, blood, or mucus

D. Is very large or small

E. Is liquid

F. Is hard

V. Conditions That Cause Abnormal Bowel Function (II-5)

A. Constipation - passage of unusually dry, hard stools; when stool is in rectum for too long, water will be absorbed from it.

B. Impaction - hard mass of stool forms in the bowel that cannot be passed normally

1. Liquid stool passes around the blockage.

2. May also note: stool incontinence, pain, discomfort, and abdominal distention.

3. Enema may be given to assist in removal or may be removed by digital exam by a licensed nurse.

C. Diarrhea - frequent passage of liquid stools

1. Note color, consistency, amount, and frequency of stool. Report to charge nurse if stool smells unusual, is not dark brown, contains undigested food, blood, or mucus or is liquid or hard.

2. Encourage p.o. fluids if not vomiting, preferably clear liquids.

3. Keep perineal area clean and dry.

D. Hemorrhoids - a varicose vein in the rectum, which may protrude from the anus and may be very tender and may bleed from irritation (II-6)

1. Caused from straining when passing stool/flatus over a long period of time

2. Lay term is "piles."

3. Note client complaint of pain, itching; blood on outside of stool; report to charge nurse.

4. Check fingernails. Client may have stool under nails from scratching.

E. Bowel obstruction - a blockage in the bowel, stool cannot pass through

1. May be caused from twisting of bowel, tumor, or large impaction of stool

2. Note client complaint of pain; abdominal distention; no passing of stool for several days; report to charge nurse.

F. Bowel incontinence - inability to stop or control passage of stool

1. Factors that can lead to bowel incontinence

a. Confusion - unable to understand where/when he/she is passing stool

b. Sphincter muscle weakness allows stool to pass.

c. Damage to nervous system may prevent message from getting to brain of client feeling urge.

G. Limited mobility and lack of assistance in getting to the bathroom - client has a problem with meeting normal need to defecate because he/she cannot hold stool if not taken to bathroom as soon as he/she feels the urge.

VI. Factors That Can Lead to Constipation (II-7)

A. Bed rest - inactivity and difficulty in using bedpan due to position; it is difficult to pass stool with legs straight out rather than squatting position

B. Inadequate fluid intake - fluid that is in stool is absorbed by the bowel

C. Lack of fibrous food in diet

D. General lack or limited activity

E. Unable to defecate at usual time or place or without privacy

F. Medications can cause constipation, for example, codeine

G. Depression - entire body slowed down

VII. Special Measures for Abnormal Bowel Function

A. These measures must be ordered by the physician:

1. Laxatives - medications taken by mouth or in suppository form to increase peristalsis and emptying of the bowel; administered by a licensed nurse or medication technician (II-8)

2. Enemas - infusion of fluid into the rectum to remove stool

a. Cleansing enemas

(1) Tap water - 1,000 cc is usual amount

(2) Soapsuds - 1 package enema soap in 1,000 cc water

VIII. Cleansing Enema

A. Cleansing enema is the introduction of fluid into the rectum in order to remove feces and flatus from the rectum and colon.

B. When are enemas given?

1. Before diagnostic test such as proctoscopy and sigmoidoscopy

2. Prior to surgery

3. During bowel retraining

4. To relieve constipation

5. To instill medications

C. Position for administering an enema (II-9)

1. The position of choice is the left Sims' position. This position allows fluid to flow into the bowel more easily. Review anatomy of rectum and sigmoid colon.

2. If the client cannot assume the Sims' position, the supine position with the client on the bedpan can be used.

3. Do not give an enema while client is on the toilet or commode.

D. Always use gloves when administering an enema.

E. Points to remember

1. Make certain the bathroom is not in use.

2. When possible, give enemas before breakfast and before the bath.

3. Always wait one hour after a meal before giving an enema.

4. A doctor's order is required before an enema can be administered.

F. Disposable enema units are available and often used.

G. If not using a disposable enema, the usual amount of solution given is 1000 cc of 105°F water. (II-10)

H. The enema tube tip is lubricated and inserted into the rectum 3 inches. NOTE: There is a danger of perforating the colon if tube is inserted more than three inches. (II-11)

I. The enema bag containing solution is never higher than 12 inches above the anus. **(II-12)**

NOTE: There is a danger of damaging the colon if the container is held too high.

J. The slower the solution is administered the better the results of the enema will be.

K. The enema solution should be retained as long as possible. Assist the client by applying slight pressure over the anal region by holding or pressing buttocks together.

L. Always wash, rinse, and dry the peri area thoroughly after the client has expelled the enema.

M. If the client has severe cramps or pain which do not go away or if he/she starts perspiring heavily or feels faint, discontinue the enema and notify the charge nurse.

IX. Demonstrate Procedure for Giving and Removing a Bedpan, Administering an Enema, and Collecting a Stool Specimen. **(II-9 - 12)**

X. Summary and Conclusion

A. Terms and definitions

B. Factors that maintain normal bowel elimination

C. Characteristics of normal stool

D. Characteristics of abnormal stool

E. Conditions that cause abnormal bowel function

F. Factors that can lead to constipation

G. Special measures for abnormal bowel function

H. Cleansing enema

I. Review procedures for giving and removing a bedpan, administering an enema, and collecting a stool specimen.

The elimination of stool is usually a daily occurrence for each client. Remember to respect his/her privacy and not embarrass the client by your comments or actions. Also remember the nursing measures to promote proper bowel functioning. It is vital for the comfort of your client. The next unit is on the skeletal system.

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

STEPS OF PROCEDURE FOR ASSISTING CLIENT IN USING BEDPAN:

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Client should be in supine position; turn back top bedding.

   NOTE: Sprinkle powder on bedpan to prevent sticking.

7. Client is able to assist
   a. Have client flex his/her knees and lift buttocks off mattress. Assist by slipping hand under the lower part of his/her back. If client has pajamas or underwear on, lower it to his/her knees.

   b. With your other hand, slip the bedpan under the client's hips and adjust.

   Client is unable to assist
   a. Turn client on his/her side away from you.

   b. Expose buttocks and position bedpan firmly against buttocks.

   c. Place small pillow/rolled towel at top of bedpan at the small of the client's back.

   d. Turn client toward you and onto the bedpan.

8. Raise the head of bed (if allowed) and side rails for client's comfort and safety. Place toilet tissue and signal cord within reach.

9. Remove gloves and dispose in appropriate container.

10. Wash your hands and leave the room.

11. Return to room promptly when the client signals or check on him/her after five minutes.

NOTE: Do not leave client on bedpan over ten minutes--may lead to extreme discomfort and result in skin breakdown.

12. Wash hands. Put on gloves.

13. Lower the head of bed and side rail of side you are on.

14. Client is able to assist - Place one hand under the small of the back and assist client to lift his/her hips. Hold bedpan with other hand.

    Client is unable to assist - Hold bedpan with one hand and roll client off pan with other hand. This will prevent contents of bedpan from spilling.

15. Remove bedpan and then cover it.

16. Wipe, wash, and dry perineal area from front to back.

17. Take bedpan to bathroom; measure urine if on I&O, and empty into toilet.

18. Clean equipment.

19. Remove gloves and dispose in appropriate container. Wash hands.

20. Store equipment.

21. Give client a clean wet washcloth to wash his/her hands, make client comfortable, and place signal cord within reach.

22. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE TO ADMINISTER AN UNMEDICATED ENEMA: (HO 1)

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Have client empty his/her bladder; assist with bedpan/bedside commode.

7. Client should be in bed, head of bed flat if it is tolerated; cover client with bath blanket and turn down top bedding.

8. Place bed protector under buttocks; assist or turn client to left Sims' position if possible. (Left side promotes flow of solution.)

9. Place bedpan at foot of bed or bedside commode near bed if client cannot go to bathroom toilet.

10. Clamp enema tubing; fill enema bag with amount of solution ordered by physician.

    NOTE: Usual amount is 1,000 cc of 105°F water.

11. Empty 5 cc liquid soap into filled container and agitate gently to distribute soap.

    NOTE: Do not make suds because this will put air into the client's bowel.

12. Expel air from tubing by allowing small amount of solution to flow into bedpan/bedside commode, then clamp/pinch tubing a few inches from tip.

13. Put about a teaspoon of lubricant on a piece of toilet tissue. Rub lubricant on lower three inches of tube.

14. Raise upper buttocks to expose anus.

15. Ask client to take a deep breath while you insert tip of rectal tube. Rotate tip slowly as you insert it three inches. If you feel resistance or if the client complains of pain, remove tube, cover client, and notify charge nurse.

16. Release lifted buttock and unclamp tubing. Hold bag or place it so that the level of the solution is never higher than 12 inches above the anus.

17. Adjust flow of solution for client's comfort--lower the bag if client complains of cramping.

    NOTE: The slower the solution goes in, the better the results from the enema.

18. Have client take deep breaths through his/her mouth to relax him/her.

19. If client has severe cramps or pain that does not pass, or if he/she starts perspiring heavily or feels faint, discontinue enema and notify charge nurse.

20. If client has trouble holding solution, stop the flow for a few minutes and then start again.

21. Clamp tube when solution is taken and remove tube, rotate it slowly and gently as you pull it out. Wrap in paper towel.

22. Ask client to retain solution as long as possible. You can assist by applying slight pressure over anal region by holding/pressing buttocks together.

23. Assist client onto bedpan/bedside commode or assist to toilet. If taken to bathroom, instruct client to not flush toilet so results can be checked.

24. Place call signal and toilet tissue within reach.

25. Remove gloves and wash your hands. Leave the room, unless assistance is needed.

26. Check on client after five minutes or before if he/she signals.

27. Wash hands. Put on gloves.

28. When client is finished, remove bedpan and observe results--note characteristics of stool.

29. Clean client with wet washcloth and dry peri area thoroughly.

30. Give client a clean, wet washcloth to wash his/her hands.

31. Place soiled washcloths in appropriate container.

32. Remove, clean, and store equipment.

33. Remove gloves and dispose in appropriate container.

34. Wash your hands.

35. Make client comfortable and place signal cord within reach.

36. Record observations and report anything unusual to charge nurse.

STEPS OF PROCEDURE FOR OBTAINING A STOOL SPECIMEN:

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Assist client onto bedpan/bedside commode or to bathroom toilet fitted with specipan.

   NOTE: Do not allow client to use bathroom toilet.

7. Ask client not to urinate or put toilet tissue into receptacle.

8. Have client wash his/her hands if he/she collected the specimen.

9. Take the covered bedpan to the client's bathroom or to the dirty utility room.

10. Using the wooden tongue depressor, take about 1 to 2 tablespoons of stool from the bedpan and place it into the specimen container.

11. Cover specimen container securely. Apply label.

12. Wrap tongue depressor in a paper towel and discard it.

13. Empty the remaining stool into the toilet/hopper.

14. Remove, clean, and store equipment.

15. Remove gloves and dispose of properly. Wash your hands.

16. Make the client comfortable; place call signal within reach.

17. Inform charge nurse that specimen has been collected; if it is not sent to the lab immediately, store according to facility's policy.

18. Record that specimen has been obtained.

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms presented in this lesson?
2. What four factors assist in maintaining normal bowel function?
3. How do you describe a normal stool?
4. What are the characteristics of abnormal stool?
5. What are some factors that may cause abnormal bowel function?
6. What is your client referring to if he/she complains about "piles?"
7. What are some factors that may lead to constipation?
8. Why does the health care assistant not administer laxatives? Who administers laxatives?
9. When an enema is given, the client should be in what position? Why?
10. What is the temperature of the enema solution for a soapsuds enema?
11. How far is the enema tube inserted into the rectum?
12. How high do you hold the enema bag containing solution?
13. What should you do if the client complains of pain and/or cramping when you are administering an enema?
14. What should you do if the client feels faint or starts perspiring heavily?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students discuss their own feelings about defecation and have students who have had to have their elimination needs taken care of by someone else tell of their feelings.
2. Instructor demonstrates giving and removing a bedpan. Students practice procedure.

3. Instructor demonstrates setting up equipment and giving an enema using Chase doll. (NOTE: Never practice an enema on a student.) Students practice setting up equipment and giving an enema on Chase doll.

4. Instructor demonstrates collecting a stool specimen. Students practice the procedure.

ANSWERS TO EVALUATION ITEMS:

1. g
2. d
3. h
4. f
5. a
6. b
7. c
8. e
9. a
10. c
11. b
12. d
13. b
14. c
15. d
16. a
17. a
18. d
19. a

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS:

Match the following terms in Column I to the correct definitions in Column II.

Column I

___ 1. Constipation
___ 2. Diarrhea
___ 3. Peristalsis
___ 4. Feces
___ 5. Distention
___ 6. Defecation
___ 7. Impaction
___ 8. Flatus

Column II

a. State of being inflated
b. Pass feces from the body
c. Hard stool that cannot pass from the rectum normally
d. Frequent passage of liquid stool
e. Gas in the bowel
f. Waste product in the bowel
g. Passage of unusually dry, hard stool
h. Wave-like movement of the bowel that pushes stool along the intestinal tract

9. Which one is NOT a factor to maintain normal bowel elimination? (Circle the letter of the best answer.)

   a. Encourage the client to drink 2,500 - 3,000 cc of fluid per 24 hours.
   b. Encourage foods low in fiber.
   c. Encourage ambulation if possible.
   d. Assist the client to maintain past habits of elimination.

10. A characteristic of a normal stool is: (Circle the letter of the best answer.)

   a. White color and hard formed
   b. Liquid and greenish color
   c. Light to dark brown and soft formed
   d. Contains mucus

11. Which is a condition that may lead to abnormal stools? (Circle the letter of the best answer.)

    a. Having a stool three times per day or every other day
    b. Impaction and hemorrhoids
    c. Ambulation and physical activity
    d. A diet high in fiber

12. What is another name for piles? (Circle the letter of the best answer.)

    a. Bowel obstruction
    b. Constipation
    c. Impaction
    d. Hemorrhoids

13. Which is a factor that can lead to constipation? (Circle the letter of the best answer.)

    a. Adequate fluid intake
    b. Inadequate fluid intake
    c. Ambulation and activity
    d. Providing privacy for defecation

14. Which one of the following health care providers does NOT administer laxatives? (Circle the letter of the best answer.)

    a. Registered Nurse
    b. Licensed Practical Nurse
    c. Nursing Assistant
    d. Medication Technician

15. The position of choice for administering an enema is: (Circle the letter of the best answer.)

    a. Knee chest
    b. Right sims
    c. Left lateral
    d. Left Sims'

16. What is the temperature of the water for a soapsuds enema? (Circle the letter of the best answer.)

    a. 105°F
    b. 110°F
    c. 115°F
    d. 120°F

17. How far is the enema tube inserted into the rectum? (Circle the letter of the best answer.)

a. 3 inches
b. 5 inches
c. 6 inches
d. 8 inches

18. While you are administering an enema, the client complains of pain or cramping that does not pass, you should: (Circle the letter of the best answer.)

a. Push the enema tube in farther.
b. Raise the height of the enema bag.
c. Tell them you will be finished in a few minutes.
d. Discontinue the enema and notify the charge nurse.

19. How high do you hold the enema container containing solution? (Circle the letter of the best answer.)

a. 12 inches
b. 16 inches
c. 20 inches
d. 22 inches

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

ASSIST CLIENT IN USING BEDPAN

EQUIPMENT:

1. Bedpan and cover
2. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Client should be in supine position; turn back top bedding. NOTE: Sprinkle powder on bedpan to prevent sticking.		
7. Client is able to help a. Have client flex his/her knees and lift buttocks off mattress. Assist by slipping hand under the lower part of his/her back. If client has pajamas or underwear on, lower it to his/her knees.		
b. With other hand, slip the bedpan under the client's hips and adjust.		
Client is unable to help a. Turn client on his/her side away from you.		
b. Expose buttocks and position bedpan firmly against buttocks.		
c. Place small pillow/rolled towel at top of bedpan at the small of the client's back.		
d. Turn client toward you and onto the bedpan.		
8. Raise the head of bed (if allowed) and side rails for client's comfort and safety. Place toilet tissue and signal cord within reach.		

9. Remove gloves and dispose in appropriate container.		
10. Wash your hands and leave the room.		
11. Return to room promptly when the client signals or check on him/her after five minutes. NOTE: Do not leave client on bedpan over ten minutes--may lead to extreme discomfort and result in skin breakdown.		
12. Wash hands. Put on gloves.		
13. Lower the head of bed and side rail of side you are on.		
14. Client is able to assist - Place one hand under the small of the back and assist client to lift his/her hips. Hold bedpan with other hand.		
Client is unable to assist - Hold bedpan with one hand and roll client off pan with other hand. This will prevent contents of bedpan from spilling.		
15. Remove bedpan and then cover it.		
16. Wipe, wash, and dry the perineal area from front to back.		
17. Take bedpan to bathroom; measure urine if on I&O, and empty into toilet.		
18. Clean equipment.		
19. Remove gloves and dispose in appropriate container. Wash hands.		
20. Store equipment.		
21. Give client a clean, wet washcloth to wash his/her hands, make client comfortable and place signal cord within reach.		
22. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ASSIST CLIENT IN USING BEDPAN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII: THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:______________

ADMINISTER AN UNMEDICATED ENEMA

EQUIPMENT:

1. Enema bag/bucket
2. Washcloths (2)
3. Enema soap (if applicable)
4. Bedpan and toilet use
5. Tap water - 105°F
6. Towels (2)
7. Disposable/reusable bed protector
8. Bath blanket
9. Water-soluble lubricant
10. IV pole to hang bag
11. Paper towels
12. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put gloves on.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Have client empty his/her bladder, assist with bedpan/bedside commode.		
7. Client should be in bed, head of bed flat if it is tolerated; cover client with bath blanket and turn down top bedding.		
8. Place bed protector under buttocks; assist or turn client to left side with knees flexed, if possible. (Left Sims' position)		
9. Place bedpan at foot of bed or bedside commode near bed if client cannot go to bathroom toilet.		
10. Clamp enema tubing; fill enema bag with amount of solution ordered by physician. NOTE: Usual amount is 1,000 cc of 105°F water.		
11. Empty 5 cc liquid soap into filled container and agitate gently to distribute soap. NOTE: Do not make suds because this will put air into the client's bowel.		

12.	Expel air from tubing by allowing small amount of solution to flow into bedpan/bedside commode, then clamp/pinch tubing a few inches from tip.		
13.	Put about a teaspoon of lubricant on a piece of toilet tissue. Rub lubricant on lower three inches of tube.		
14.	Raise upper buttocks to expose anus.		
15.	Ask client to take a deep breath while you insert tip of rectal tube. Rotate tip slowly as you insert it three inches. If you feel resistance or if the client complains of pain, remove tube, cover client, and notify charge nurse.		
16.	Release lifted buttock and unclamp tubing. Hold bag or place it so that the level of the solution is never higher than 12 inches above the anus.		
17.	Adjust flow of solution for client's comfort--lower the bag if client complains of cramping. NOTE: The slower the solution goes in, the better the results from the enema.		
18.	Have client take deep breaths through his/her mouth to relax him/her.		
19.	If client has severe cramps or pain that does not pass, or if he/she starts perspiring heavily or feels faint, discontinue enema and notify charge nurse.		
20.	If client has trouble holding solution, stop the flow for a few minutes and then start again.		
21.	Clamp tube when solution is taken and remove tube, rotate it slowly and gently as you pull it out. Wrap in paper towel.		
22.	Ask client to retain solution as long as possible. Assist by applying slight pressure over anal region by holding/pressing buttocks together.		
23.	Assist client onto bedpan/bedside commode or assist to toilet. If taken to bathroom, instruct client to not flush toilet so results can be checked.		
24.	Place call signal and toilet tissue within reach.		
25.	Remove gloves and wash your hands. Leave the room, unless assistance is needed.		
26.	Check on client after five minutes or before if he/she signals.		
27.	Wash hands. Put on gloves.		
28.	When client is finished, remove bedpan and observe results--note characteristics of stool.		

29. Clean client with wet washcloth and dry peri area thoroughly.		
30. Give client a clean wet washcloth to wash his/her hands.		
31. Place soiled washcloths in appropriate container.		
32. Remove, clean, and store equipment.		
33. Remove gloves and dispose in appropriate container.		
34. Wash your hands.		
35. Make client comfortable and place signal cord within reach.		
36. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ADMINISTER AN UNMEDICATED ENEMA" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 37

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VII : THE DIGESTIVE SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

COLLECT STOOL SPECIMEN

EQUIPMENT:

1. Bedpan and cover
2. Gloves
3. Specimen container and label
4. Tongue depressor

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Assist client onto bedpan/bedside commode or to bathroom toilet fitted with speci-pan. NOTE: Do not allow client to use bathroom toilet.		
7. Ask client not to urinate or put toilet tissue into receptacle.		
8. Have client wash his/her hands if he/she collected the specimen.		
9. Take the covered bedpan to the client's bathroom or to the dirty utility room.		
10. Using the wooden tongue depressor, take about 1 to 2 tablespoons of stool from the bedpan and place it into the specimen container.		
11. Cover specimen container securely. Apply label.		
12. Wrap tongue depressor in a paper towel and discard it.		
13. Empty the remaining stool into the toilet/hopper.		
14. Remove, clean, and store equipment.		
15. Remove gloves and dispose of properly. Wash your hands.		

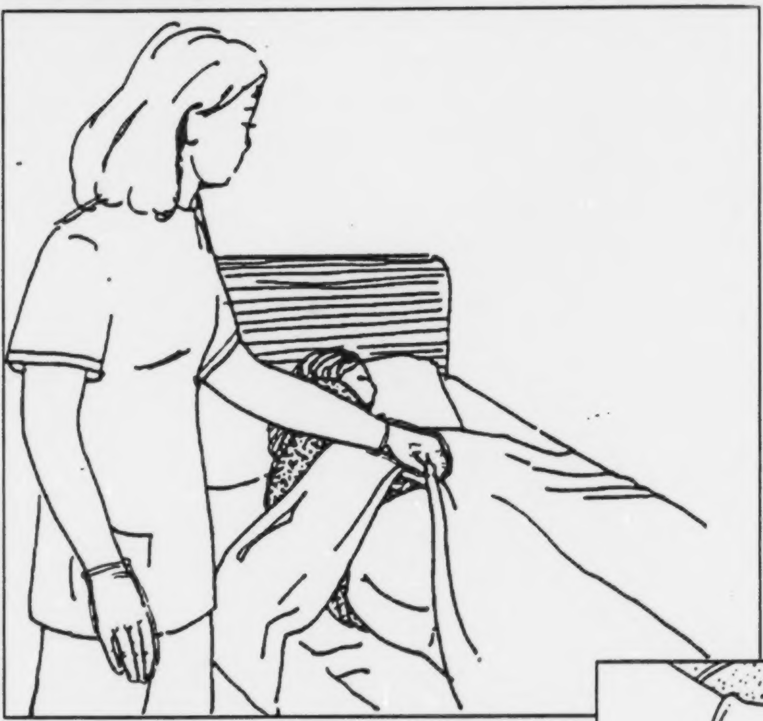
16.	Make the client comfortable; place call signal within reach.		
17.	Inform charge nurse that specimen has been collected; if it is not sent to the lab immediately, store according to facility's policy.		
18.	Record that specimen has been obtained.		

The student has satisfactorily completed the procedure "COLLECT STOOL SPECIMEN" according to the steps outlined.

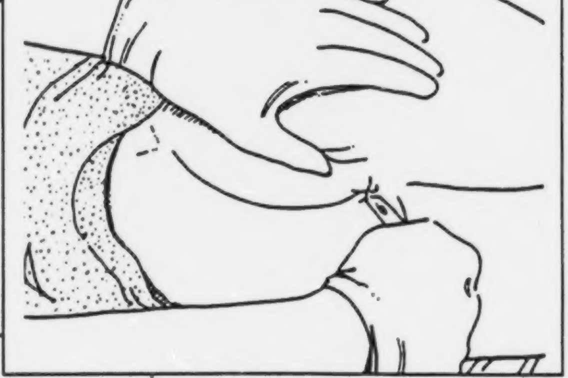
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

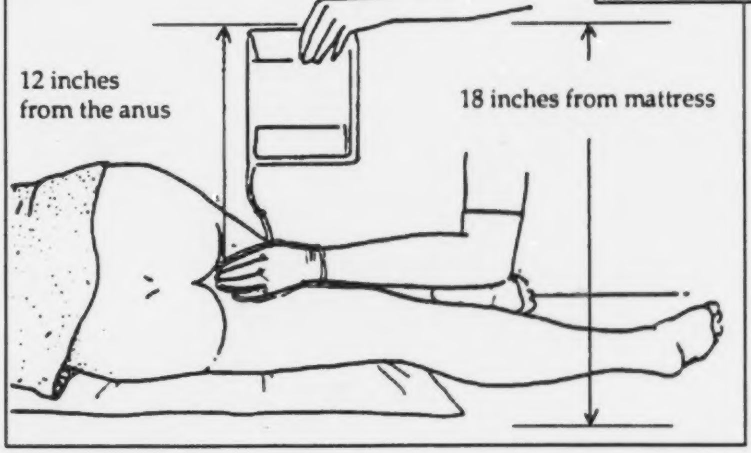
ADMINISTERING AN ENEMA



1. Position client in left Sims' position.



2. Insert enema tubing 3 inches.


12 inches from the anus
18 inches from mattress

3. Level of enema bag

LESSON PLAN: 38

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-38 OR DEMONSTRATION:

SKELETAL SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with the correct definition.
2. List the functions of the skeletal system.
3. Identify the four types of bones and where they are located.
4. Describe the function of synovial fluid.
5. Match the four types of diarthroses joints with their locations.
6. Identify the types of joint movements by matching movement with picture examples.
7. Label a diagram of the structure of long bones and their linings.
8. Identify the location of selected bones of the body by labeling a diagram of the skeleton.
9. Explain the difference between ligament and cartilage.
10. Match disorders of bones and joints with the correct description of the disorder.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Types of Joints
2. HO 2: Normal Range of Movements
3. HO 3: Long Bone Structure

4. HO 4: Frontal View of Skeleton

5. HO 5: Posterior View of Skeleton

6. HO 6: Skeletal Parts

7. HO 7: Vertebrae

8. Anatomical model

9. Wall charts

10. State Fair Community College Media Center

    a. An Introduction to the Skeletal System, video HO-91-530
    b. Organization of the Axial Skeleton, video HO-91-531
    c. The Appendicular Skeleton - The Pectoral Girdle, video HO-91-532
    d. The Appendicular Skeleton - The Pelvic Girdle, video HO-91-533

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 38 (Student Reference page 597) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

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Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

The skeletal system consists of 206 bones. This system forms the framework of the body, just as a building is supported by a wood or metal structure. Some bones are hinged and others are fused to other bones. The average growth of bone is 18 years for the female and 20 to 21 years for the male.

The male and female skeleton are different. The male skeleton is usually larger. The male and female hipbones are different. The female pelvis has a broad shallow shape and the pelvic inlet is wider so that a baby can be cradled in the pelvis and pass through it at birth.

LESSON PLAN: 38

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

A. Bone fracture - any break of bone

B. Cartilage - tough, strong tissue; found in nose, ears, and at the ends of bones

C. Joint - place where two bones meet

D. Ligament - sheet of tough tissue that holds bones together at the joint

E. Sprain - injury to a ligament

F. Arthritis - inflammation of a joint

G. Iliac - pertaining to the ilium

H. Osteitis - inflammation of a bone

I. Temporomandibular joint - connects the upper and lower jaw

J. Vertebral discs - discs of the spinal column down the middle of the back

K. Atlas - first cervical vertebra

L. Amphiarthrosis - partially moveable joint

M. Diarthrosis - moveable joint

N. Synarthrosis - immoveable joint

O. Axis - second cervical vertebra

P. Ball and socket joint - one bone has a ball-shaped head which nestles into a concave socket of the second bone.

Q. Hinge joints - move in two directions: flexion and extension; Ex. knee and elbow

R. Pivot joint - those with an extension rotating in a second arch-shaped bone; Ex. radius and ulna

S. Gliding joints - those in which nearly flat surfaces glide across each other; Ex. vertebrae of the spine

T. Tendon - fibrous cords which connect muscles to bones

U. Bursa - joint capsule

V. Synovial - joint cavity

II. Functions of the Skeletal Structure **(II-2)**

A. Supports and gives form and shape to the body

B. Protects the delicate internal organs of the body, brain, and spinal cord

C. Movement and anchorage of muscles - muscles attached to the skeleton are called skeletal muscles. These muscles contract and exert a pull upon a bone and move it.

D. Mineral storage - they store calcium and phosphorus. Our body can draw upon these reserves in times of need.

E. Hemopoiesis - the red marrow of the bone is the site of blood cell formation

III. Bone types **(II-3)**

A. Long bones - upper and lower arms and legs

B. Flat bones - skull bones

C. Irregular - bones of the spinal column

D. Short bones - cube-like in shape; bones of wrist and ankle

IV. Joints - point of contact between two bones (HO 1)

A. Classification

1. Diarthroses

2. Amphiarthroses

3. Synarthroses

B. Movable joints are covered with a smooth, slippery cap of cartilage called articular cartilage. It helps to absorb jolts. Movable joints do not touch one another.

1. Movable joints consist of

a. Articular cartilage

        b. Joint capsule

        c. Synovial - joint cavity

    2. Articular capsule encloses the two articular surfaces of the bone. It is a tough, fibrous connective tissue capsule.

    3. Synovial membrane lines the articular capsule.

    4. The synovial membrane secretes synovial fluid.

    5. Synovial fluid is a lubricating substance that reduces the friction of joint movement. **(II-4)**

C. Types of diarthroses joints **(II-5)**

    1. Ball and socket joints - provide the greatest amount of movement; shoulders and hips

    2. Hinge - knees, elbows, and outer joints of the fingers

    3. Pivot - radius and ulna (the long bones of the forearms), wrists, ankles, atlas (first cervical vertebra which supports the head), and axis, (second cervical vertebra which allows the head to rotate)

    4. Gliding joint - have nearly flat surfaces and glide across each other; includes the vertebrae of the spine (allows the torso to bend forward, backward, and sideways and to rotate) and small bones of the wrist and ankle

D. Amphiarthroses joints

    1. Cartilage located between their articular surfaces

    2. Include the attachment of the ribs to the spine, symphysis pubis, and the joint between the two pubic bones

E. Synarthroses joints

    1. They are found in the adult cranium.

    2. Cranial joints are commonly called sutures.

    3. They are fused together and provide a protective cover for the brain.

V. Types of Movement of Joints (HO 2) **(II-6)**

A. Flexion - bending movement in which angle between two adjoining bones is decreased

B. Extension - straightening a joint; movement of a part which increases the angle between two adjoining bones

C. Abduction - movement away from midline

D. Adduction - movement toward the midline

E. Rotation - twisting or pivoting bone around a central axis without a change in position of bone

F. Supination - position of bones in forearm in anatomic position

G. Pronation - position of the bones in forearm with the back of hand turned forward

VI. Structure and Formation of Bones

A. Bones are composed of microscopic cells called osteocytes.

B. Bones are made up of 35 percent organic material and 65 percent inorganic mineral salts.

C. Structure of a long bone (HO 3) **(II-7)**

1. Diaphysis or shaft

2. Epiphysis - extreme ends of the diaphysis

3. Medullary canal - center of the shaft; filled with yellow bone marrow which contains blood vessels and cells that form leukocytes (white blood cells)

4. Endosteum - lines the marrow canal

5. Periosteum - tough fibrous tissue that contains blood vessels, lymph vessels and nerves

a. Outside of bone is covered with the periosteum.

b. Periosteum is necessary for bone growth repair and nutrition.

VII. Divisions of the Skeletal System (HOs 4, 5, & 6) **(II-8)**

A. Axial skeleton - 80 bones

1. Skull - 29 bones

a. Cranial bones

(1) Frontal - forehead bone

(2) Parietal - bulging form on the topside of cranium

(3) Temporal - lower side of cranium

(4) Occipital - back of skull

(5) Sphenoid - central part of the floor of the cranium

(6) Ethmoid - helps form the floor of the cranium, sidewalls and roof of mouth, part of middle partition, nasal septum, and part of orbit

b. Facial bones

(1) Nasal - upper part of the bridge of the nose

(2) Maxillary - upper jawbone

(3) Zygoma (malar) - cheek bones

(4) Lacrimal - forms medial wall of eye socket and sidewall of nasal cavity

(5) Palatine - back part of roof of mouth and floor, sidewalls of nose and part of floor of orbit

(6) Inferior turbinate - curved ledge along inside of sidewalls of nose; one of the three turbinate bones

(7) Vomer - lower back part of the nasal septum

c. Ear bones

(1) Malleus - tiny bone in middle ear cavity in temporal bone; shaped like a hammer

(2) Incus - also in middle ear; shaped like an anvil

(3) Stapes - also in middle ear; shaped like a stirrup

2. Vertebral column - 26 bones (HO 7)

a. Cervical - 7 in upper neck region; first one called atlas; second called axis

b. Thoracic - 12 attached to ribs

c. Lumbar - 5 in small of back

d. Sacrum - 5 separate vertebrae in children; fused into one in adults

e. Coccyx - tail bone; 3 to 5 separate vertebrae in children; fused into one vertebrae in adults

3. Ribs and sternum - 25 bones

a. True ribs - 7 upper pairs (14 in all) attach to sternum by way of costal cartilages

b. False ribs - 3 pairs attached to sternum by way of costal cartilage of the 7th rib

c. Floating ribs - 2 pairs called floating ribs because they do not attach to the sternum or the costal cartilages

d. Sternum - 1 breastbone; a piece of cartilage at the lower end of bone called xiphoid process

B. Appendicular skeleton - 126 bones

1. Upper extremities - 64 bones

a. Clavicle - 2; collarbone

b. Scapula - 2; shoulder blade

c. Humerus - 2; upper arm

d. Radius - 2; bone on thumb side of lower arm

e. Ulna - 2; bone on little finger side of lower arm

f. Carpal bones - 16; irregular-shaped bones at upper end of hand; anatomical wrist

g. Metacarpals - 10; forms framework of hand

h. Phalanges - 28; bones of the fingers, three in each finger and two in each thumb

2. Lower extremities - 62 bones

a. Pelvic bone - 2

(1) Ilium - hip bone, upper flaring part

(2) Ischium - lower back part

(3) Pubic bone - lower front part

(4) Acetabulum - hip socket

            - (5) Symphysis pubis - joint in middle between the two pubic bones
            - (6) Pelvic inlet - opening into pelvic cavity
        - b. Femur - 2; upper leg bone (the thigh)
        - c. Patella - 2; kneecap
        - d. Tibia - 2; shinbone
        - e. Fibula - 2; lateral side of lower leg (the long slender bone)
        - f. Tarsal bones - 14; heel and back part of foot (anatomical ankle)
        - g. Metatarsals - 10; part of foot to which toes attach
        - h. Phalanges - 28; toe bones; three in each toe, two in each big toe

VIII. Ligaments and Cartilage **(II-9)**

- A. Ligaments - strong bands of connective tissue that hold bone to bone
- B. Cartilage - white, fibrous connective tissue attached to ends of bones to prevent friction

IX. Disorders of Bones and Joints **(II-10, 11)**

- A. Osteoporosis
    - 1. Osteoporosis is due to loss of minerals of the bones.
    - 2. It is caused by a deficiency in male or female hormones.
    - 3. Bones are brittle and fracture easily.
    - 4. Hormones and minerals may slow the process.
- B. Arthritis
    - 1. Inflammatory condition of one or more joints, accompanied by pain and deformity
    - 2. Types
        - a. Osteoarthritis
            - (1) The most common type of arthritis
            - (2) Often called degenerative joint disease

(3) Affects joints that receive a great deal of wear and tear, usually the lower extremity joints and the spine

(4) Usually occurs after 45 years of age

b. Rheumatoid

(1) Chronic systemic disease affecting the connective tissues and joints

(2) Most crippling; causes multiple deformities

(3) Joints are very swollen and painful.

(4) Affects three times more women than men

(5) Unknown cause

c. Gout

(1) Usually involves but is not limited to inflammation of the great toe

(2) Caused by faulty uric acid metabolism

C. Bursitis

1. Inflammation specifically of the synovial bursa (sac surrounding the structure that makes up the joint) which cushions a joint during movement

2. Calcium deposits may form within the joint (elbow, knee, or shoulder joints)

D. Malformations caused by injury

1. Sprain - injury to a ligament which usually causes swelling and pain

2. Dislocation - usually of the hip or shoulder; involves a disruption of the joint which results in the bones being in an abnormal position

3. Fractures

a. Simple (closed) fractures are of several types including:

(1) Complete - most common; results in two or more separate. fragments of the bone

(2) Incomplete or greenstick - splitting or splintering of the bone

b. Compound (open) fractures - skin being broken as well as the bone

E. Rickets

   1. Disease of the bones.

   2. Caused by a lack of vitamin D.

   3. The soft bones bend, causing bowlegs and pigeon breast.

F. Microcephalus - a congenital condition in which there is a marked diminution in the size of the cranium due to early ossification of the sutures of the skull

G. Spina bifida - a congenital condition in which the vertebral column, which contains the spinal cord, does not develop completely and close properly

H. Scoliosis - lateral curvature of the spine

I. Subluxation - a vertebra is displaced from its normal position or normal range of movement, without having been completely dislocated. Sometimes referred to as a whiplash by lay people.

J. Osteitis - inflammation of bone tissue

K. Ewing's sarcoma - a malignant tumor of the bone marrow

X. Summary and Conclusion

A. Terms and definitions

B. Functions of the skeletal system

C. Bone types

D. Joints

E. Types of movement of joints

F. Structure and formation of bones

G. Divisions of the skeletal system

H. Ligaments and cartilage

I. Disorders of bones and joints

In this lesson we have discussed the structure and function of the skeletal system. The next lesson will be the muscular system which will explain how muscles provide the movement for bones.

LESSON PLAN: 38

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms in this lesson?
2. What are the functions of the skeletal system?
3. Where are long bones, flat bones, irregular bones, and short bones located?
4. What is the function of synovial fluid?
5. Where are the ball and socket, hinge, pivot, and gliding joints located?
6. How do you demonstrate flexion, extension, abduction, adduction, rotation, supination, and pronation?
7. Where are the epiphysis, bone marrow cavity, periosteum, diaphysis, endosteum, compact bone, and cancellous bone located?
8. Where are each of the bones of the skeletal system located?
9. What is the function of ligaments and cartilage?
10. What are 10 disorders of bones and joints?
11. How do you describe the 10 disorders of bones and joints?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. View slide-tape series.
2. Identify the major bones on anatomical model or wall chart.
3. Obtain a long bone from meat market - have them cut it lengthwise. Identify parts.
4. Label drawings of skeleton.
5. Examine bones on skeleton and identify types of bones.
6. Have class demonstrate the joint movements.
7. Bring a chicken leg or wing to class for demonstration and discussion on joints, and attachments of ligaments.

ANSWERS TO EVALUATION ITEMS:

1. f
2. b
3. e
4. a
5. c

6. a. Support
   b. Protection
   c. Anchor for skeletal muscles
   d. Produce blood cells
   e. Store calcium

7. d
8. c
9. c
10. d
11. a
12. b
13. d
14. e
15. b
16. a
17. c
18. f

19. Clockwise: f, b, c, e, g, d, a

20. a
21. e
22. i
23. n
24. t
25. w
26. b
27. f
28. h
29. p
30. v
31. c
32. g
33. k
34. r
35. d
36. j
37. m
38. o
39. q
40. l
41. a
42. e
43. b
44. a
45. f
46. d

LESSON PLAN: 38

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I

___ 1. Tendon
___ 2. Cartilage
___ 3. Joint
___ 4. Ligament
___ 5. Bursa

Column II

a. Sheet of tough tissue that holds bones together at the joint
b. Tough, strong tissue; found in nose, ears, and at the ends of bones
c. Joint capsule
d. Moveable joint
e. Place where two bones meet
f. Fibrous cords which connect muscles to bones

6. List the five functions of the skeletal system.

a.

b.

c.

d.

e.

7. Long bones are located in the: (Circle the letter of the best answer.)

a. Skull
b. Spinal column
c. Wrist and ankle
d. Upper and lower arms and legs

8. What is the lubricating substance that reduces the friction of joint movement called? (Circle the letter of the best answer.)

   a. Bursa fluid
   b. Articular fluid
   c. Synovial fluid
   d. Gliding fluid

Match the types of diarthroses joints in Column I with the location of the joint in Column II.

	Column I		Column II
____ 9.	Pivot	a.	Vertebrae of spine, small bones of wrist and ankle
____ 10.	Ball and socket	b.	Knees, elbows, outer joints of fingers
____ 11.	Gliding	c.	Radius and ulna
____ 12.	Hinge	d.	Shoulders and hips

Match the terms describing joint movements with picture examples:

____ 13. Flexion

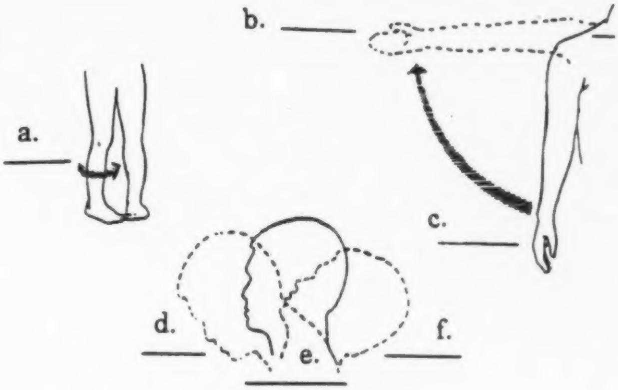
____ 14. Extension

____ 15. Abduction

____ 16. Rotation

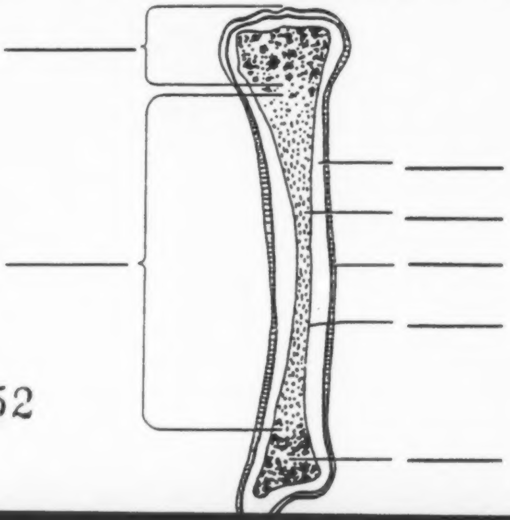
____ 17. Adduction

____ 18. Hyperextension



19. Label the diagram of the long bone by writing the letter of the correct term in the blank.

   a. Epiphysis
   b. Bone marrow cavity
   c. Periosteum
   d. Diaphysis
   e. Endosteum
   f. Compact bone
   g. Cancellous bone



Label the correct parts of the skeleton by placing the corresponding letter next to the line identifying the skeleton part.

____ 20. Occipital

____ 21. Metatarsals

____ 22. Patella

____ 23. Ulna

____ 24. Clavicle

____ 25. Parietal

____ 26. Maxilla

____ 27. Tarsals

____ 28. Tibia

____ 29. Ribs

____ 30. Mandible

____ 31. Pelvis

____ 32. Fibula

____ 33. Phalanges

____ 34. Sternum

____ 35. Phalanges

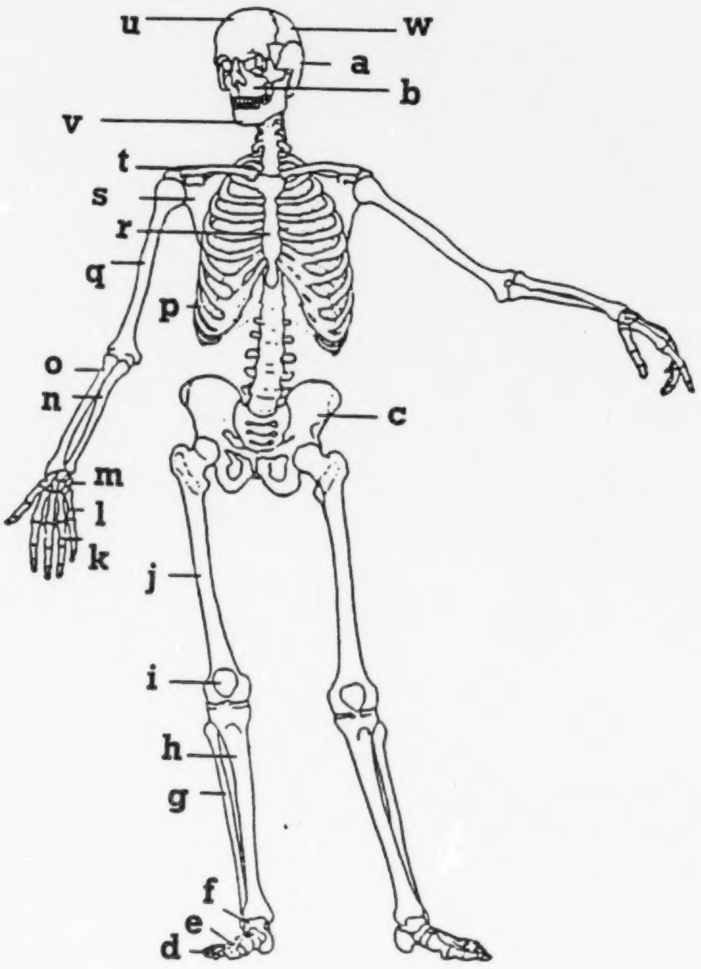
____ 36. Femur

____ 37. Carpals

____ 38. Radius

____ 39. Humerus

____ 40. Metacarpals



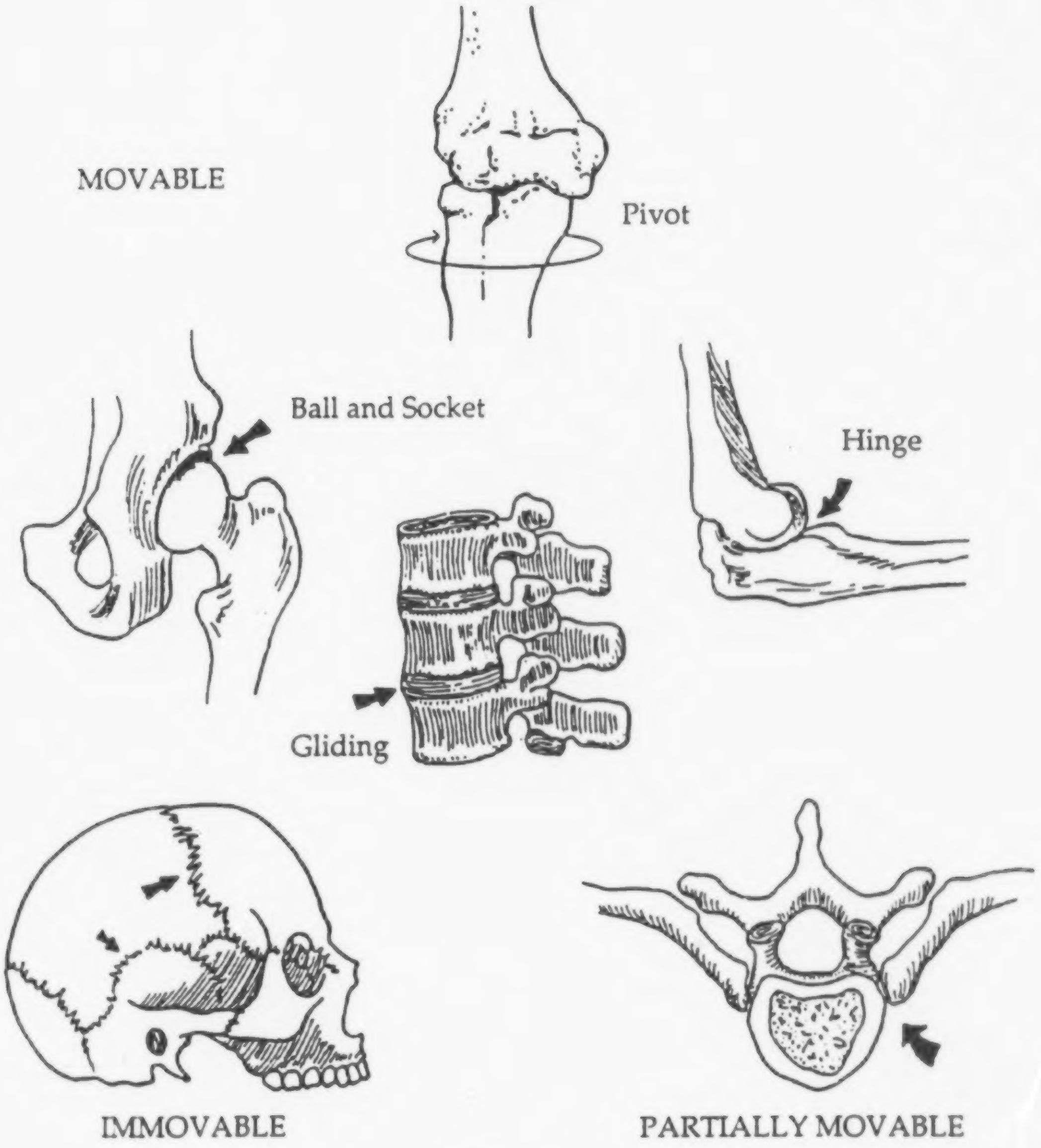
41. Which is the correct description of ligaments? (Circle the letter of the best answer.)

- a. Strong bands of connective tissue that hold bone to bone.
- b. The center of the bone shaft.
- c. Lining of the bone marrow canal.
- d. White, fibrous connective tissue attached to ends of bones.

Match the disorder in Column I with the correct description of the disorder in Column II.

		Column I		Column II
____	42.	Arthritis	a.	Injury to a ligament
____	43.	Osteoporosis	b.	Bones are brittle and fracture easily
____	44.	Sprain	c.	Inflammation of bone tissue
____	45.	Greenstick fracture	d.	Lateral curvature of the spine
____	46.	Scoliosis	e.	Inflammatory condition of one or more joints
			f.	Splitting or splintering of the bone

TYPES OF JOINTS


MOVABLE
Pivot
Ball and Socket
Hinge
Gliding
IMMOVABLE
PARTIALLY MOVABLE

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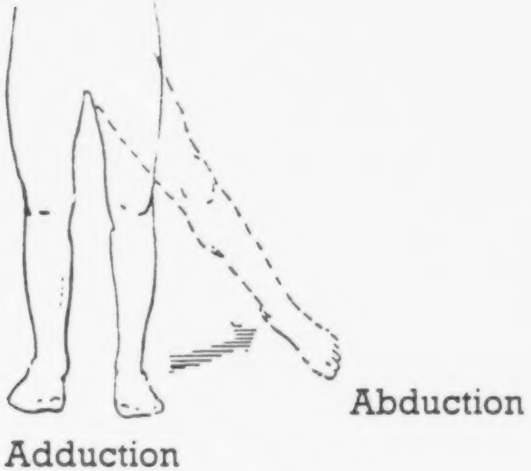
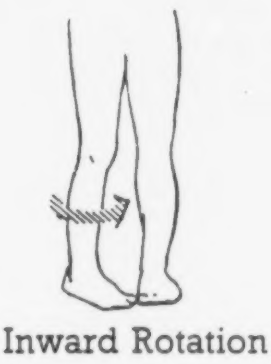
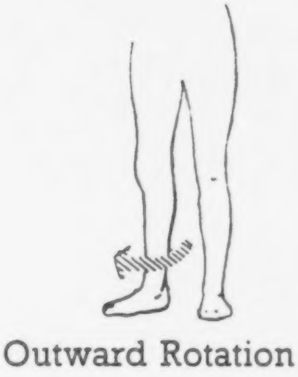
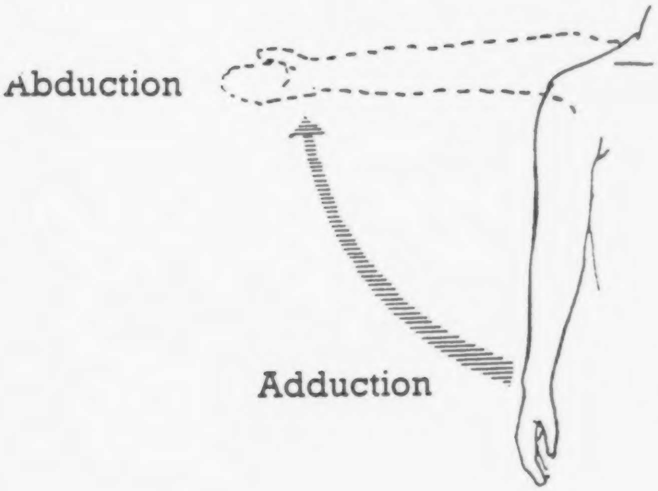
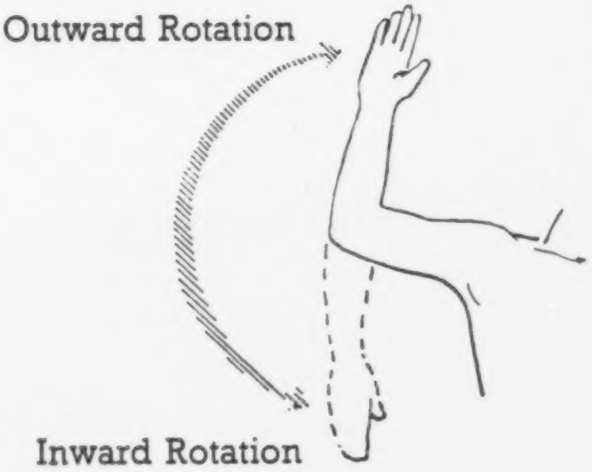
NORMAL RANGE OF MOVEMENTS

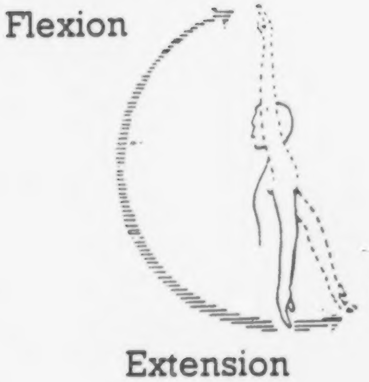

Abduction
Adduction


Inward Rotation

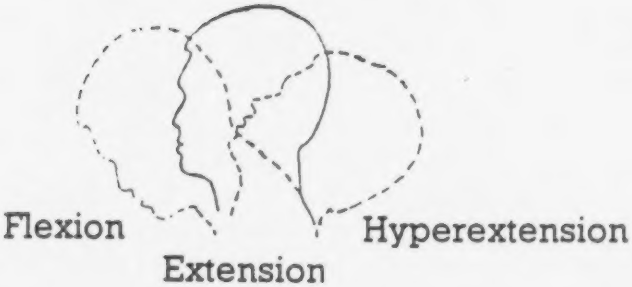

Outward Rotation


Abduction
Adduction

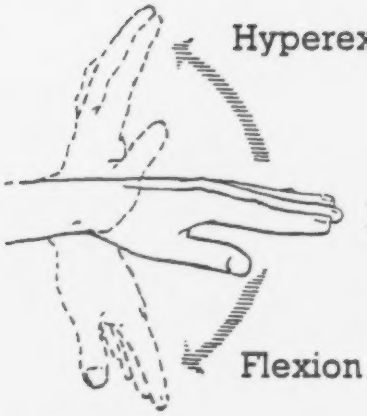

Outward Rotation
Inward Rotation



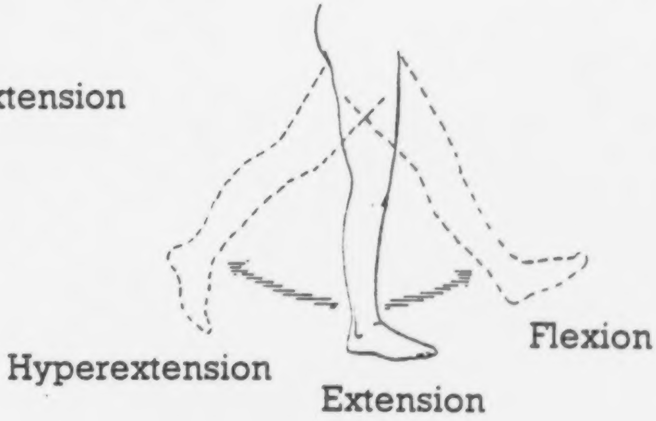
Flexion
Hyperextension
Extension



Flexion
Extension
Hyperextension

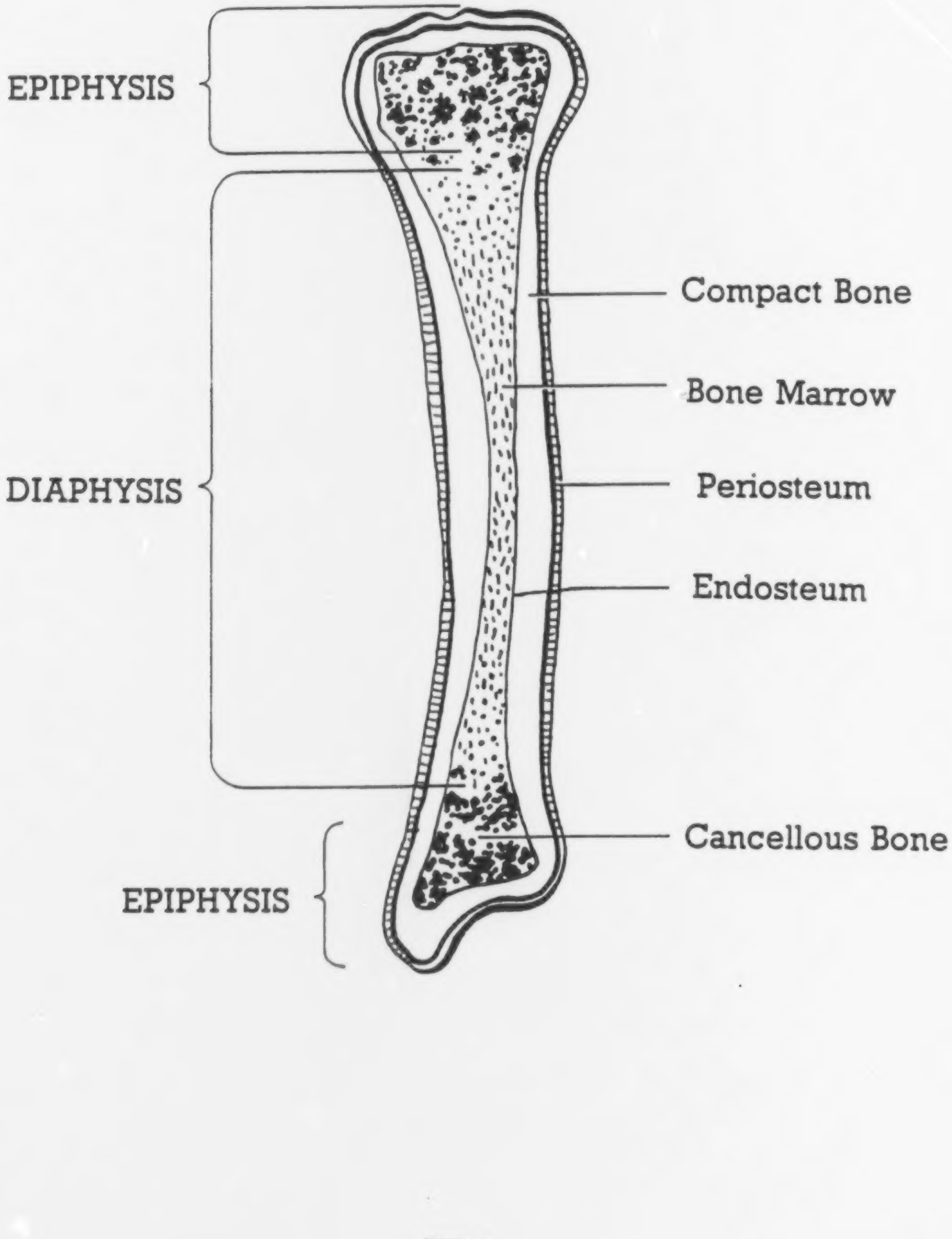


Hyperextension
Extension
Flexion

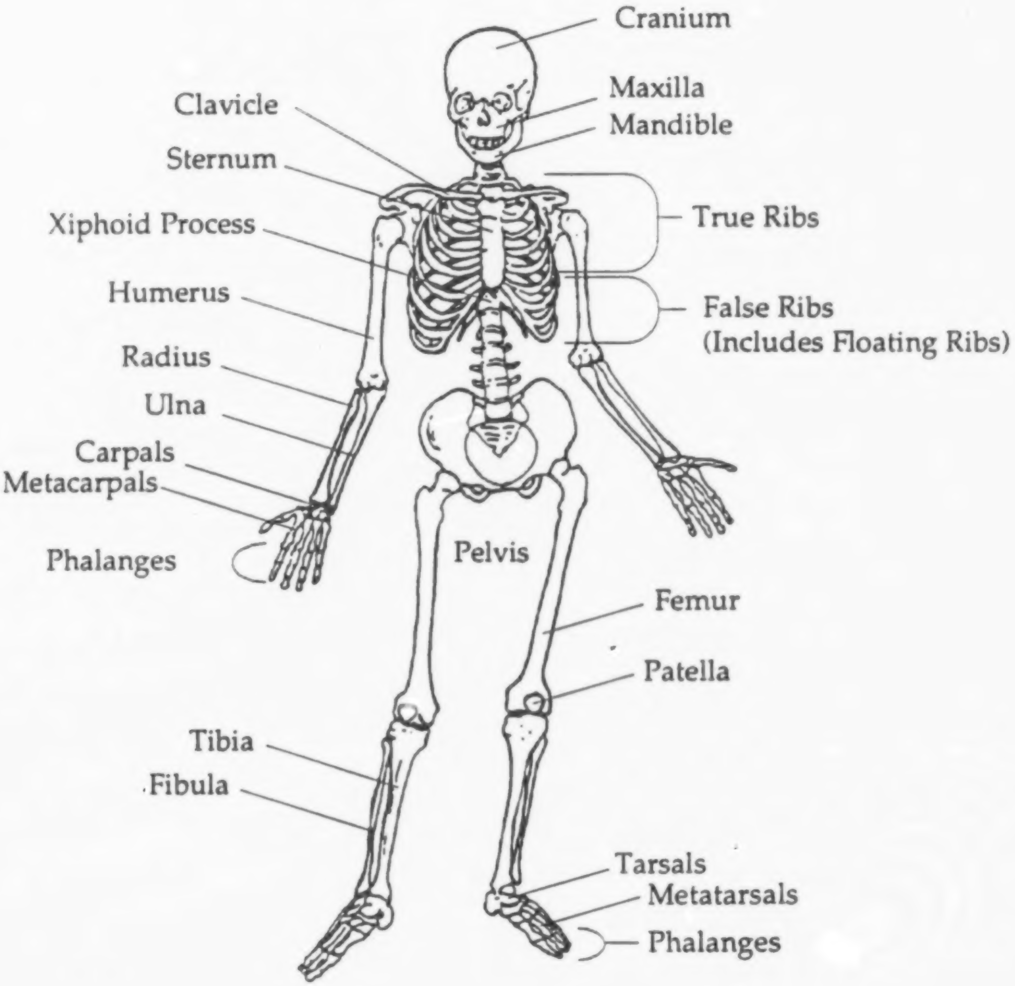


Hyperextension
Extension
Flexion

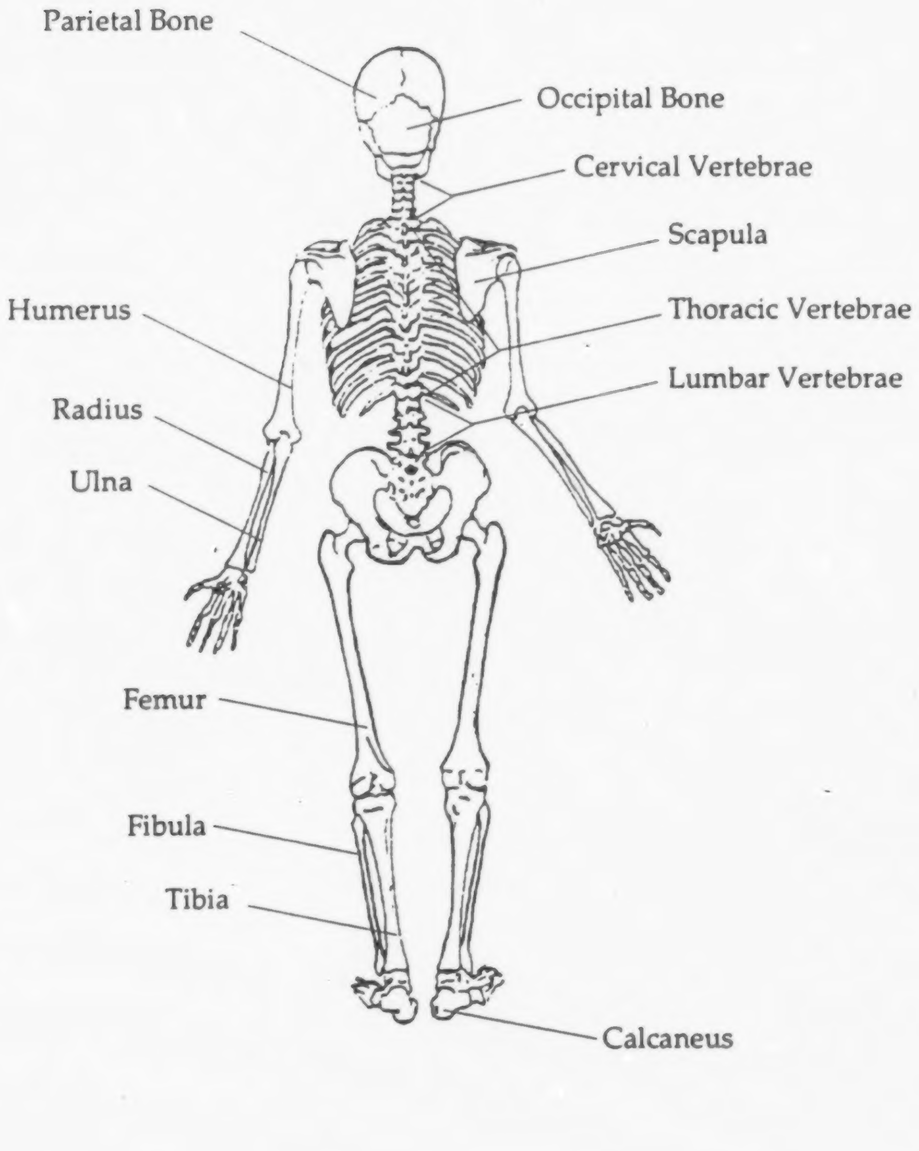
LONG BONE STRUCTURE


EPIPHYSIS
DIAPHYSIS
EPIPHYSIS
Compact Bone
Bone Marrow
Periosteum
Endosteum
Cancellous Bone

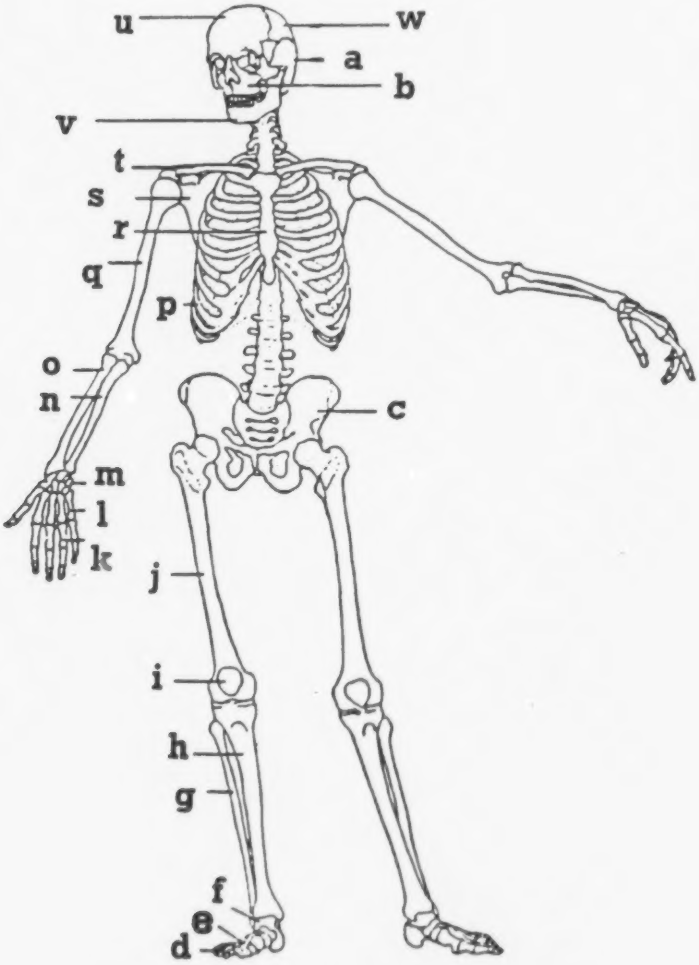
FRONTAL VIEW OF SKELETON


Cranium
Maxilla
Mandible
Clavicle
Sternum
Xiphoid Process
True Ribs
False Ribs
(Includes Floating Ribs)
Humerus
Radius
Ulna
Carpals
Metacarpals
Phalanges
Pelvis
Femur
Patella
Tibia
Fibula
Tarsals
Metatarsals
Phalanges

POSTERIOR VIEW OF SKELETON

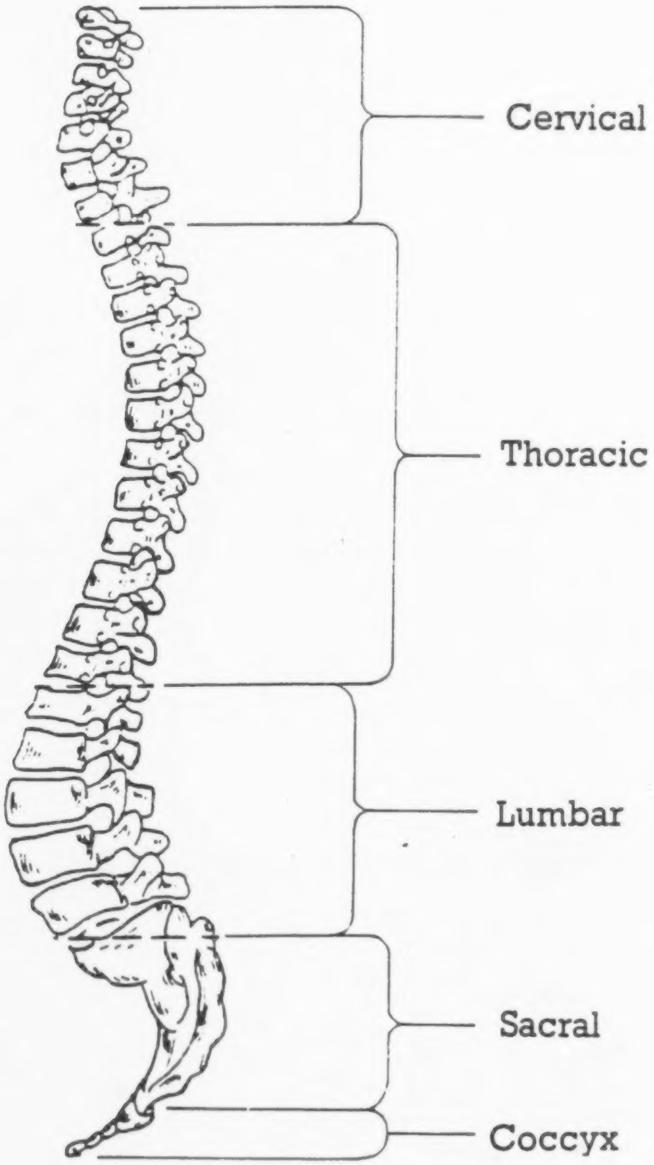

Parietal Bone
Occipital Bone
Cervical Vertebrae
Scapula
Humerus
Thoracic Vertebrae
Lumbar Vertebrae
Radius
Ulna
Femur
Fibula
Tibia
Calcaneus

SKELETAL PARTS



a. Occipital	i. Patella	q. Humerus
b. Maxilla	j. Femur	r. Sternum
c. Pelvis	k. Phalanges	s. Scapula
d. Phalanges	l. Metacarpals	t. Clavicle
e. Metatarsals	m. Carpals	u. Frontal
f. Tarsals	n. Ulna	v. Mandible
g. Fibula	o. Radius	w. Parietal
h. Tibia	p. Ribs	

VERTEBRAE


Cervical
Thoracic
Lumbar
Sacral
Coccyx

LESSON PLAN: 39

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-39 OR DEMONSTRATION:

MUSCULAR SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with their correct definitions.
2. Describe the four types of muscle cells and their functions.
3. Identify the parts of a skeletal muscle.
4. Describe the functions of skeletal muscles.
5. Identify how muscles are attached.
6. Match the major classes of muscles with their functions.
7. Match the major muscles with their functions in the muscular system.
8. Describe common muscular deficits or disorders

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Types of Muscle Cells
2. HO 2: Muscle Parts
3. HO 3: Muscles
4. Anatomical model

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 39 (Student Reference page 621) prior to class and be prepared to discuss the information presented.

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INTRODUCTION:

The study of muscles is called myology. The muscular system includes over 600 pairs of muscles in the body. They make up over 40 percent of our body weight. Muscles allow us to move our bodies as well as move different parts of our body. In addition, they help the body stay erect, determine our posture, and produce most of the body's heat.

LESSON PLAN: 39

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Myalgia - muscle pain

   B. Myasthenia - weakness of the muscle

   C. Myocardial - pertaining to the muscular tissue of the heart

   D. Locomotion - act of moving from place to place

   E. Cardiac muscle - muscle of the heart

   F. Skeletal muscle - muscles attached to a bone or bones of the skeleton; aids body movement; a form of voluntary (striated) muscle

   G. Viscera - internal organs

   H. Voluntary - under control of will

   I. Sphincter - circular muscle - example: anus

   J. White muscle - skeletal muscle that appears paler in flesh than red muscle

   K. Abduction - movement away from midline of body

   L. Adduction - movement of part of body toward midline of body

   M. Contractibility - muscle's ability to shorten or contract

   N. Extensibility - muscle's ability to be stretched

   O. Elasticity - ability of muscle to return to its original length when relaxing

   P. Origin - part of skeletal muscle that is attached to a fixed structure or bone

   Q. Insertion - part of the muscle attached to a moveable bone or fixed structure

   R. Antagonist pair - when a pair of body muscles produce movement in opposite directions

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S. Pronation - to turn downward; Ex. rotation of the forearm so that the palm of the hand is turned downward

T. Supination - turn palm of hand up

U. Muscle fatigue - accumulation of lactic acid in the muscle

V. Muscle tone - muscles in good health are slightly contracted and ready to work.

W. Axial muscle group - the head, face, neck, and trunk muscles

X. Appendicular muscle group - extremity muscles

Y. Atrophy - wasting away of tissue (muscle shrinkage)

Z. Diaphragm - dome-shaped muscle separating the thoracic and abdominal cavities

AA. Flexion - making angle at joint smaller

AB. Extension - making angle at joint larger

II. Types of Muscle Cells and Their Functions (HO 1) **(II-2, 3)**

A. Smooth muscles - involuntary (not under conscious control); visceral located in the walls of tubular structures and hollow organs, such as the digestive tract, urinary bladder, and blood vessels

1. Propel materials through passageways of body (food in intestinal tract)
2. Constrict or dilate openings (pupils of eye)
3. Contract or expand the width of tubes (veins and arteries)
4. Expel materials from body (bile from gallbladder)

B. Cardiac muscle - located in the heart

1. Forms the wall of the heart
2. Acts involuntarily (contracts to circulate blood) and are rhythmic and automatic
3. Requires a continuous supply of oxygen to function

C. Skeletal muscle - voluntary; striated; attached to the bones of the skeleton and also located in the wall of the pharynx and esophagus

1. About 40 percent of body weight
2. Contractions occur voluntarily and may be rapid and forceful

3. Structure

    a. Bundle of muscle tissue surrounded by connective tissue

    b. Acts on nerve impulses

D. Sphincter muscles - circular muscles in the walls of the anus and urethra; constricts a passage or closes a natural opening in the body

III. Parts of Skeletal Muscle (HO 2) **(II-4)**

A. Origin - less movable end

B. Body or belly - main part; fleshy

C. Insertion - more movable end

IV. Functions of Skeletal Muscle **(II-5)**

A. Movement - locomotion

B. Heat production

C. Protection

D. Maintain posture

V. Muscle Attachment **(II-6)**

A. Connective tissue - directly to bone

B. Tendon - cord of fibrous connective tissue that attaches a muscle to a bone or other structure

C. Aponeurosis - flattened sheet of white, fibrous connective tissue; serves as attachment for flat muscles, or a sheet enclosing/binding muscle groups

VI. Classes of Muscles **(II-7)**

A. Prime movers - produce definite motion

B. Antagonist - movement opposite prime mover

C. Synergist - aids prime mover

D. Fixator - keeps bone steady at origin while prime mover pulls away

VII. Major Muscles and Their Functions (HO 3) **(II-8)**

A. Sternocleidomastoid - flexes and rotates head

B. Biceps - flexes elbow

C. Triceps - straightens elbow

D. Deltoid - raises and lifts arm

E. Trapezius - raises shoulder and arm up and backward

F. Pectoralis major (chest muscles) - pull arm and shoulder in toward body

G. Latissimus dorsi - pulls arm down and backward and rotates the trunk of the body

H. Rectus abdominous - protects the abdominal organs and pulls body forward

I. Quadriceps femoris - pulls leg upward and forward

J. Tibialis anterior - pulls foot upward and slightly lateral

K. Gastrocnemius - extends foot and connects with Achilles tendon

L. Gluteus maximus - protects buttocks and extends thigh

M. Hamstrings - flexes lower leg and extends thigh

N. Sartorius - aids in flexing knee, longest in body

VIII. Common Muscular Deficits or Disorders **(II-9)**

A. Paralysis - temporary or permanent loss of muscle function to a part of the body; caused by injury, trauma, or illness

B. Contracture - temporary or permanent shortening (abnormal) of a muscle which results in a "frozen" or fixed joint; caused by paralysis or disuse; begins 3 to 7 days after immobilization of a part; completed in 6 to 8 weeks

C. Muscular dystrophy - a genetic muscle disease which causes progressive atrophy and muscle wasting.

IX. Summary and Conclusion

A. Terms and definitions

B. Types of muscles

C. Parts of skeletal muscle

D. Functions of skeletal muscle

E. Muscle attachment

F. Classes of muscles

G. Major muscles and their functions

H. Common muscular deficits or disorders

This lesson has covered the structure and function of the muscular system. The next lesson will show how to use body mechanics to lift and move clients.

LESSON PLAN: 39

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. What is the definition of terms found in this lesson?
2. What are four types of muscle cells?
3. What are the functions of the four types of muscle cells?
4. What are the parts of a muscle?
5. What functions do skeletal muscles perform?
6. How are muscles attached?
7. What are the classes of muscles?
8. What functions do muscles perform?
9. What are three common muscular deficits or disorders?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. View slides of muscle tissue.
2. Examine muscle tissue obtained from butcher shop.
3. Identify muscles on anatomical model and have students describe their actions.

ANSWERS TO EVALUATION ITEMS:

1. f
2. a
3. e
4. b
5. d
6. d
7. e
8. f
9. c
10. b
11. f

12. e
13. b
14. a
15. c
16. d
17. b
18. a
19. c
20. d
21. b
22. b
23. d
24. f
25. b
26. g
27. e
28. a
29. c
30. d

LESSON PLAN: 39

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definition in Column II.

	Column I		Column II
____ 1.	Skeletal muscle	a.	Under control of will
____ 2.	Voluntary	b.	Movement of part of body toward midline
____ 3.	Abduction	c.	Muscle pain
____ 4.	Adduction	d.	Ability of muscle to return to its original length when relaxing
____ 5.	Elasticity	e.	Movement away from the midline of the body
		f.	Muscle attached to bone

Match the terms in Column I with the correct definition in Column II.

	Column I		Column II
____ 6.	Sphincter	a.	Muscle of the heart
____ 7.	Viscera	b.	Act of moving from place to place
____ 8.	Contractibility	c.	Ability of muscle to stretch
____ 9.	Extensibility	d.	Circu[illegible] muscle
____ 10.	Locomotion	e.	Internal organs
		f.	Muscle's ability to shorten

Match the terms in Column I with the correct definition in Column II.

Column I		Column II	
____ 11.	Origin	a.	Making angle of joint smaller
____ 12.	Insertion	b.	Muscle shrinkage
____ 13.	Atrophy	c.	Making angle of joint larger
____ 14.	Flexion	d.	Muscles are in good health
____ 15.	Extension	e.	Part of the muscle attached to a moveable part
		f.	Part of the muscle attached to a fixed structure or bone

Match the terms in Column I with the correct definition in Column II.

Column I		Column II	
____ 16.	Sphincter	a.	Attached to bones
____ 17.	Smooth	b.	Constricts or dilates
____ 18.	Skeletal	c.	Forms the walls of the heart
____ 19.	Cardiac	d.	Walls of the anus and urethra

20. The origin of a muscle is the: (Circle the letter of the best answer.)

    a. Main flesh part.
    b. More movable end.
    c. Locomotion part.
    d. Less movable end.

21. What is a function of skeletal muscles? (Circle the letter of the best answer.)

    a. Constrict openings
    b. Protection
    c. Rhythmic contractions
    d. Expansion

22. Muscles are attached to bone by: (Circle the letter of the best answer.)

    a. Prime movers.
    b. Tendons.
    c. Serous fluid.
    d. Pronation.

Match the major muscles in Column I with their functions in Column II.

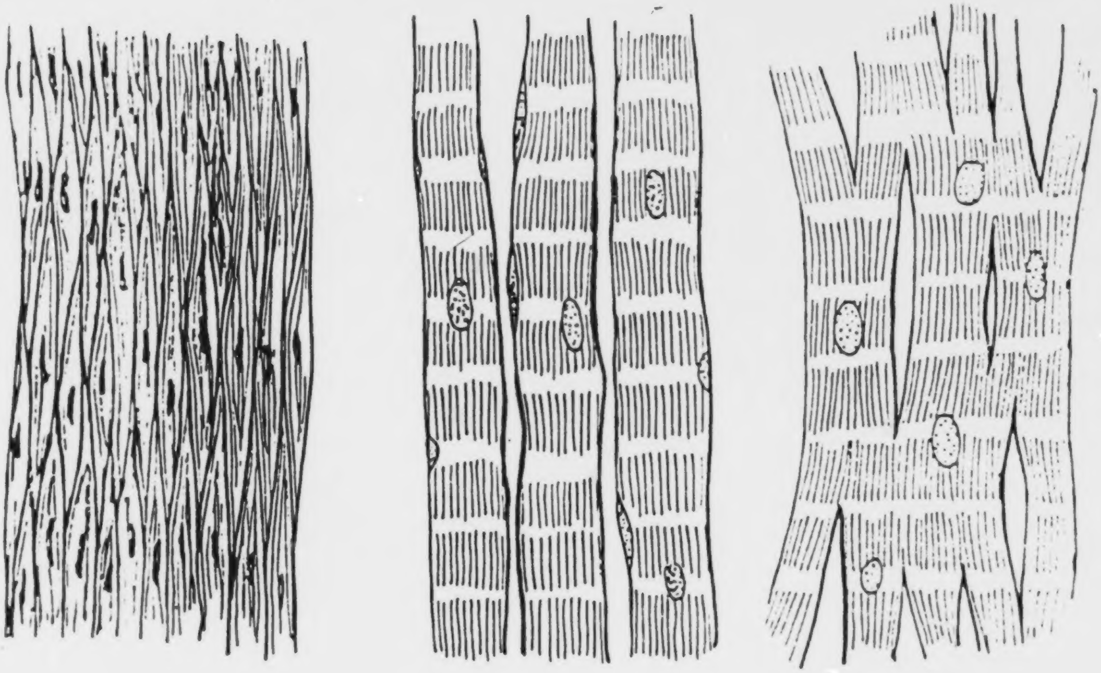
Column I		Column II
____ 23. Latissimus dorsi	a.	Raises and lifts arms
____ 24. Triceps	b.	Flexes lower leg and extends thigh
____ 25. Hamstrings	c.	Protects buttocks and extends thigh
____ 26. Gastrocnemius	d.	Pulls arm down and backward and rotates the trunk of the body
____ 27. Pectoralis major	e.	Chest muscle - pulls arm and shoulder in toward body
____ 28. Deltoid	f.	Straightens elbow
____ 29. Gluteus maximus	g.	Extends foot and connects with Achilles tendon

30. A contracture is: (Circle the letter of the best answer.)

   a. Temporary or permanent loss of muscle function to a part of the body.
   b. A genetic muscle disease.
   c. Dystrophy which causes progressive muscle wasting.
   d. Temporary or permanent shortening of a muscle which results in a fixed joint.

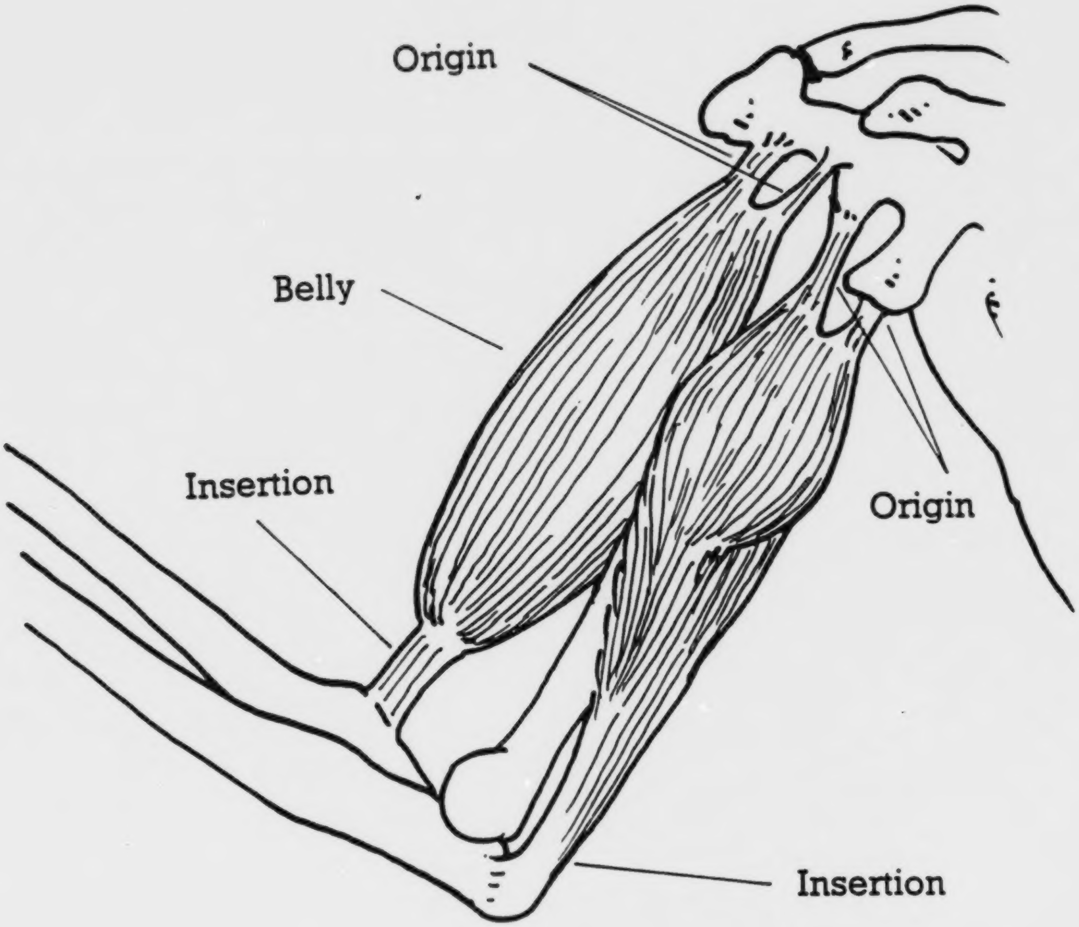
HO 1

TYPES OF MUSCLE CELLS



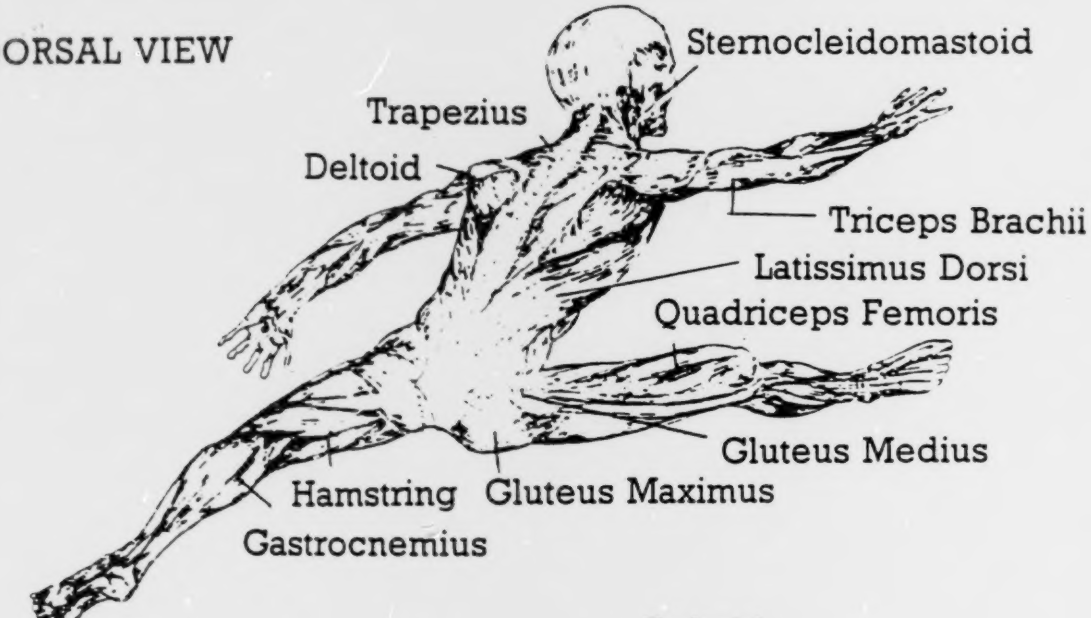
Smooth Striated Cardiac

MUSCLE PARTS

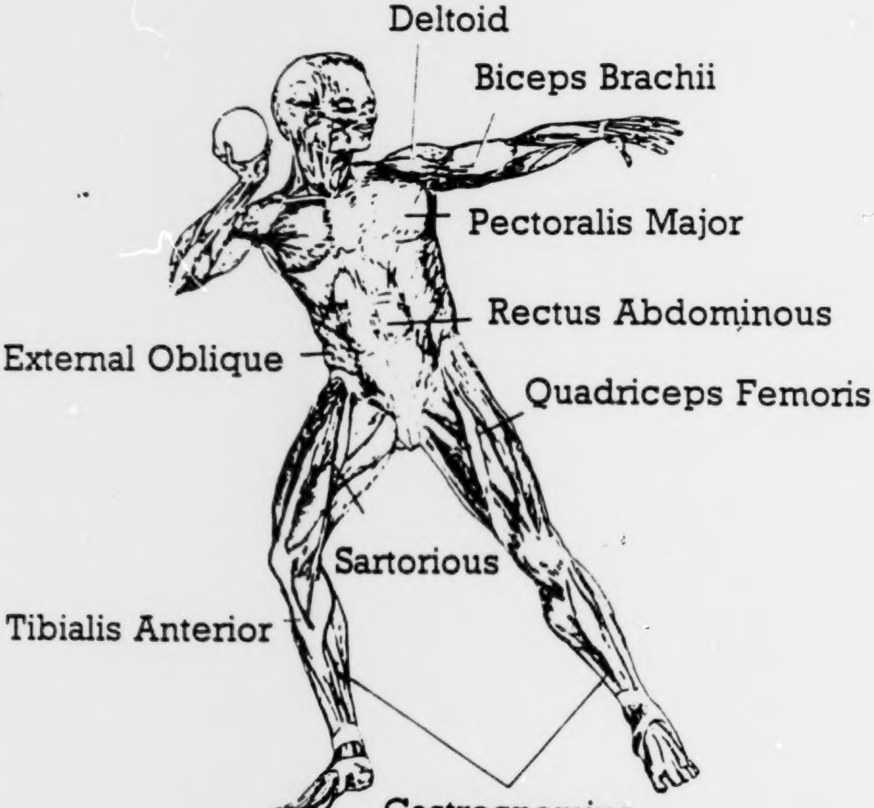

Origin
Belly
Insertion
Origin
Insertion

MUSCLES

DORSAL VIEW


Sternocleidomastoid
Trapezius
Deltoid
Triceps Brachii
Latissimus Dorsi
Quadriceps Femoris
Gluteus Medius
Hamstring
Gluteus Maximus
Gastrocnemius

VENTRAL VIEW


Deltoid
Biceps Brachii
Pectoralis Major
Rectus Abdominous
External Oblique
Quadriceps Femoris
Sartorious
Tibialis Anterior
Gastrocnemius

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-40 AND DEMONSTRATION: VIII-40

USING BODY MECHANICS TO LIFT AND MOVE CLIENTS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Identify important points to remember when lifting and moving a client.

Demonstration

2. Assist/raise client's head and shoulders.
3. Move/assist client to head of bed according to the steps of procedure.
4. Move helpless client to head of bed according to the steps of procedure.
5. Move client to one side of the bed according to the steps of procedure.
6. Turn client to side according to the steps of procedure.
7. Turn client to prone position according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Moving the Client in Bed
2. HO 2: Turning the Client
3. Positioning Techniques, video #19, available from the Missouri Vocational Resource Center, (14 min.)
4. Television and VCR

5. Bed with side rails

6. Two pillows - additional blankets/towels as needed

7. Handroll/washcloth

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 40 (Student Reference page 635) prior to class and be prepared to discuss the information presented and return the demonstrations on moving and lifting clients.

REFERENCES:

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Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapters 27 & 28.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 12, Section 5.

Schniedman, Rose; Susan Lambert; Barbara, Wander. Being a Nurse Assistant. 5th ed. The Hospital Research and Educational Trust, 1989.

Sorrentino, Sheila. Mosby's Textbook for Nursing Assistant, 3rd ed. St. Louis, MO: Mosby Year Book Inc., 1992. Chapter 10.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 2, Section 1 and Chapter 7.

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INTRODUCTION:

As a health care assistant, one of your duties will be to move clients. You must know how to do this without straining your back and causing an injury to yourself or the client. There are ways to use your body to reduce strain and fatigue and that is what this lesson will cover. Remember your feet are your base of support. Your strongest and largest muscles are in the shoulders, upper arms, hips, and thighs. These are the muscles which we use to lift and move heavy objects. As you study each procedure, close your eyes and visualize each step of the procedure.

Clients will often need help when moving in the bed. You must assess your client properly to determine if you can move him/her by yourself or if you will need help. If the procedure requires two persons due to the client being "dead weight," very heavy, or one with very fragile skin, use a pull/lift sheet. This will prevent friction and irritation to the skin. Keep in mind the principles of body mechanics anytime you are moving the client. Remember, reduce body friction when moving a client by rolling or lifting. Never slide the client. Sliding can cause skin break down.

Proper positioning of the client in the bed is necessary to maintain normal body function, to prevent contractures, to assure comfort, and to prevent pressure on one area of the body. Body alignment is the proper relationship of body parts to each other to avoid unnecessary strain/injury. Always look at the client when positioning him/her to see if the body is straight and looks comfortable; check to make sure no bony areas are pressing/rubbing on the mattress. The following procedures will assist you in understanding the steps to take for moving a client.

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

OUTLINE: (HOs 1 & 2)

I. Points to Remember When Lifting and Moving A Client (II-1)

A. Lifting and moving helpless or nearly helpless clients is a major responsibility of the health care assistant

B. Before lifting or moving a client, determine if you need help. If they weigh more than you do, get help.

C. If the client has special equipment such as IVs or oxygen, get help.

D. The most support is given to the client's heaviest part of his/her body.

E. Always hold the client close to your body for the best support.

F. Use smooth and steady motions when lifting and moving.

G. Position chair against a solid surface such as wall or a piece of furniture. This will prevent the chair from sliding.

H. Gloves are worn if there is a possibility of contact with wet linen, blood, or body fluids.

I. Use a turning sheet for turning. The turning sheet is placed from above the client's shoulders to below his/her hips. A turning sheet can be used to turn or move clients.

J. Always make certain the client's body is in good body alignment and check condition of skin.

K. Remember, if you do not correctly lift and move the client, you can cause injury to the client and/or yourself.

II. Demonstrate Procedures for Lifting and Moving Clients

III. Summary and Conclusion

A. Points to remember when lifting and moving a client

B. Review procedures for lifting and moving clients

This lesson has covered steps for using body mechanics to lift and move clients. Your next lesson will be bed making. You must also apply all principles of body mechanics when making a bed.

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

STEPS OF PROCEDURE FOR ASSISTING/RAISING CLIENT'S HEAD AND SHOULDERS:

1. Wash your hands.

2. Identify and greet client. Identify self.

3. Explain what you are going to do.

4. Provide privacy.

5. Check that bed wheels are locked.

6. Raise bed to level where you can use good body mechanics.

7. Make certain far side rail is raised.

8. Lower side rail near you.

9. Face the head of the bed with your feet shoulder width apart, one foot slightly ahead of the other.

10. Instruct client to put his/her near arm under your near arm and behind your shoulders. (II-2)

    NOTE: His/her hand should be on your shoulder.

11. Put your arm under the client's arm near you.

    NOTE: Your hand should be on his/her shoulder.

12. Put your other arm under the client's neck and shoulders.

    NOTE: Use this hand to turn pillow.

13. Help client lie down. Provide support with your locked arm. Support his/her neck and shoulders with the other arm.

14. Make certain client is in good body alignment.

15. Place signal light.

16. Raise side rail near you if it is to be up.

17. Lower bed to lowest position.

18. Wash your hands.

STEPS OF PROCEDURE FOR MOVING/ASSISTING CLIENT TO HEAD OF BED:

1. Wash your hands.

2. Identify and greet client. Identify self.

3. Explain what you are going to do.

4. Provide privacy.

5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; lower side rail on side at which you are working.

6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.

7. Move pillow to headboard so client does not hit his/her head when moving up.

8. Help client bend his/her knees and press feet firmly against the mattress.

9. If client is able, have him/her grasp head of bed, otherwise cross his/her arms over chest.

10. Slide one arm under client's shoulders and the other under the thighs. (II-3)

11. Stand facing head of the bed with your feet 18 inches apart. One foot should be slightly ahead of the other.

12. On the count of three, have the client push with his/her feet and you shift your weight from your back leg to your front leg as you slide the client up in the bed.

13. Replace pillows.

14. Adjust backrest for comfort.

15. Lower bed to a position of safety; raise side rails where ordered.

16. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

17. Wash your hands.

STEPS OF PROCEDURE FOR MOVING HELPLESS CLIENT TO HEAD OF BED:

1. Ask another health care assistant to work with you.

2. Identify and greet client. Identify self and other health care assistant.

3. Explain what you are going to do.

4. Provide privacy.

5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; lower side rail on side at which you are working.

6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.

7. Move pillow to headboard so client does not hit his/her head when moving up.

8. Health care assistants should stand on opposite sides of the bed.

9. Position a draw sheet/folded regular sheet under shoulders and hip area. Each health care assistant should roll edges of sheet toward client's body and grasp rolled sheet with his/her hands at the client's shoulders and at the mid-hip area. **(II-4)**

10. Your feet should be pointed in the direction you are moving the client; bend knees, keep back straight.

11. On the count of three, each health care assistant lifts the client up off the surface of the bed and toward the head of the bed while shifting weight from back foot to front foot.

12. Replace pillow.

13. Adjust backrest for comfort.

14. Lower bed to a position of safety; raise side rails where ordered.

15. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

16. Wash your hands.

STEPS OF PROCEDURE FOR MOVING CLIENT TO SIDE OF THE BED:

1. Wash your hands.

2. Identify and greet client. Identify self.

3. Explain what you are going to do.

4. Provide privacy.

5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; lower side rail on side at which you are working.

6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.

7. Remove pillow and loosen top sheets, but don't expose the client.

8. Stand on the side of the bed toward which you intend to move client.

9. Slide both arms under the client's back to his/her far shoulder, then slide the client's shoulders toward you on your arms.

   NOTE: Keep your knees bent and your back straight as you slide the client.

10. Slide both your arms as far as you can under the client's buttocks and slide his/her buttocks toward you. Use a lift sheet whenever possible.

11. Place both your arms under the client's feet and slide them toward you on your arms.

12. Replace pillows.

13. Adjust backrest for comfort.

14. Lower bed to a position of safety; raise side rails where ordered.

15. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

16. Wash your hands.

STEPS OF PROCEDURE FOR TURNING THE CLIENT TO SIDE:

1. Wash your hands.

2. Identify and greet client. Identify self.

3. Explain what you are going to do.

4. Provide privacy.

5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; and lower side rail on side from which you are working.

6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.

7. Loosen the top sheets without exposing the client. Remove pillow.

8. Check to see that the client has ample space to turn without getting too close to the edge of the bed. If not, have client move over more in bed, or you move the client to the side of the bed that he/she is not turning to.

9. Cross the client's arms over his/her chest. (II-5)

10. Turning client toward you
    a. Cross the leg farthest from you over the leg closest to you.
    b. Reach across the client and put one hand behind his/her far shoulder.
    c. Place your other hand behind his/her far hip, gently roll him/her toward you.

    Turning client away from you
    a. Cross the leg closest to you over the leg farthest from you.
    b. Place one hand on the client's shoulder near you.
    c. Put your other hand under client's buttocks, turn him/her gently on his/her side, facing away from you.

11. Fold a pillow lengthwise and place it against the client's back for support.

12. Support the client's head with the palm of one hand and slide a pillow under his/her head and neck with the other hand.

13. Position client's knees slightly flexed, upper leg more than the lower leg. Support upper leg on pillow.

14. Support upper arm on pillow.

15. Place handroll or rolled washcloth in hand with thumb in opposition to fingers.

16. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

17. Lower bed to a position of safety; raise side rails where ordered.

18. Wash your hands.

STEPS OF PROCEDURE FOR TURNING CLIENT TO PRONE POSITION: (II-6)

1. Wash your hands.

2. Identify and greet client. Identify self.

3. Explain what you are going to do.

4. Provide privacy.

5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; and lower side rail on side from which you are working.

6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.

7. Loosen top sheets, do not expose client. Remove pillows.

8. Move client to side of bed you are on.

9. Turn client to side.

10. Move client to side of bed you are on.

11. Arm near center should be away from body.

12. Cross upper leg over lower leg.

13. Roll client onto abdomen.

14. Place small, firm pillow/folded blanket under the head. Do not use a full pillow as it may cause neck strain and interfere with breathing.

    CAUTION: Clients can smother if left unsupervised in prone position.

15. Place small, firm pillow under one shoulder.

16. For female clients, place small, firm pillow under abdomen to prevent pressure on breasts.

17. Extend feet over end of mattress or slightly elevate feet off mattress by flexing knees and placing pillow under lower legs.

18. Place handroll or rolled washcloth in hand with thumb in opposition to fingers.

19. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

20. Lower bed to a position of safety; raise side rails if ordered.

21. Wash your hands.

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. What are some important points that the health care assistant should remember when lifting and moving a client?
2. Where is the client's arm placed when you are assisting him/her to raise his/her head and shoulders?
3. Where are your arms placed when assisting or moving a client to the head of the bed?
4. How is a draw sheet positioned under the client?
5. What are the steps of procedure for moving a client to the side of the bed?
6. How do you position a client in the prone position?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisuals.
2. Have each student lift box off floor using proper body mechanics.
3. Show anatomy diagram of muscle groups used when lifting.
4. Have a class discussion on good posture.
5. Have the class see how long they can balance on one foot.
6. Instructor demonstrates how to move a client up in the bed and how to move a client from one side of the bed to the other.
7. Students practice moving another student up in bed and from one side of the bed to the other.
8. Instructor demonstrates turning and positioning client on side.
9. Instructor demonstrates turning and positioning client in the prone position.
10. Students practice turning and positioning client on side and prone positions.

ANSWERS TO EVALUATION ITEMS:

1. b
2. d
3. a
4. b
5. b
6. c
7. a

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

1. Before lifting or moving a client, the health care assistant should: (Circle the letter of the best answer.)

   a. Give the most support to the lightest part of the body.
   b. Get help if he/she weighs more than you.
   c. Hold the client away from your body.
   d. Position the chair facing the bed.

2. When assisting or raising a client's head and shoulder, you should: (Circle the letter of the best answer.)

   a. Place one hand under the client's axilla and grasp his/her far arm with your other hand.
   b. Instruct the client to grasp you around the neck with both arms and push up with the heels.
   c. Place one hand under the client's shoulders and the other hand under his/her buttocks.
   d. Instruct the client to put his/her near arm under your near arm, with his/her hand behind your shoulders.

3. To assist a client to the head of the bed, you should: (Circle the letter of the best answer.)

   a. Slide one arm under client's shoulders and the other under the thighs.
   b. Slide one arm under client's buttocks and the other arm under the lower legs.
   c. Slide one arm under the client's neck and the other arm under the small of the back.
   d. Slide one arm under the client's head and the other arm under the buttocks.

4. Where is a turning sheet positioned? (Circle the letter of the best answer.)

   a. Under the buttocks and lower legs area
   b. Under the shoulders and hip area
   c. Under the head and shoulder area
   d. Under the lower thighs to the ankle area

5. Which one of the following is an incorrect step of procedure for moving a client to the side of the bed? (Circle the letter of the best answer.)

   a. First, slide both arms under client's back to his/her far shoulder, then slide his/her shoulders toward your arms.
   b. Keep your knees straight and your back bent as you slide the client toward you.
   c. Secondly, slide both arms under the client's buttocks and slide the buttocks toward you.
   d. Thirdly, place both your arms under the client's feet and slide the feet toward you on your arm.

6. How do you turn a client toward you? (Circle the letter of the best answer.)

   a. Place one hand on the client's shoulder near you.
   b. Cross the leg closest to you over the leg farthest from you.
   c. Cross the leg farthest from you over the leg closest to you.
   d. Put your hand under the client's buttocks and slide him/her facing away from you.

7. Which of the following is correct when positioning a client in the prone position? (Circle the letter of the best answer.)

   a. The feet should extend over the end of the mattress.
   b. A pillow should be placed under the upper thighs.
   c. The feet should be positioned at right angles.
   d. Feet should be pointing upward.

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

ASSIST/RAISE CLIENT'S HEAD AND SHOULDERS

EQUIPMENT:

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Provide privacy.		
5. Check that bed wheels are locked.		
6. Raise bed to level where you can use good body mechanics.		
7. Make certain far side rail is raised.		
8. Lower side rail near you.		
9. Face the head of the bed with your feet shoulder width apart, one foot slightly ahead of the other.		
10. Instruct client to put his/her near arm under your near arm and behind your shoulders. NOTE: His/her hand should be on your shoulder.		
11. Put your arm under the client's arm near you. NOTE: Your hand should be on his/her shoulder.		
12. Put your other arm under the client's neck and shoulders. NOTE: Use this hand to turn pillow.		
13. Help client lie down. Provide support with your locked arm. Support his/her neck and shoulders with the other arm.		
14. Make certain client is in good body alignment.		
15. Place signal light.		
16. Raise side rail near you if it is to be up.		

17. Lower bed to lowest position.		
18. Wash your hands.		

The student has satisfactorily completed the procedure "ASSIST/RAISE CLIENT'S HEAD AND SHOULDERS" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

MOVE/ASSIST CLIENT TO HEAD OF BED

EQUIPMENT:

1. Bed with side rails

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Provide privacy.		
5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; lower side rail on side at which you are working.		
6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
7. Move pillow to headboard so client does not hit his/her head when moving up.		
8. Help client bend his/her knees and press feet firmly against the mattress.		
9. If client is able, have him/her grasp head of bed, otherwise cross his/her arms over chest.		
10. Slide one arm under client's shoulders and the other under the thighs.		
11. Stand facing the head of the bed with feet 18 inches apart. One foot should be slightly ahead of the other.		
12. On the count of three, have the client push with his/her feet as you shift your weight from your back leg to your front leg as you slide the client up in the bed.		
13. Replace pillows.		
14. Adjust backrest for comfort.		

15.	Lower bed to a position of safety; raise side rails where ordered.		
16.	Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
17.	Wash your hands.		

The student has satisfactorily completed the procedure "MOVE/ASSIST CLIENT TO HEAD OF BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

MOVE HELPLESS CLIENT TO HEAD OF BED

EQUIPMENT:

1. Bed with side rails
2. Lift sheet/folded bed sheet

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Ask another health care assistant to work with you.		
2. Identify and greet client. Identify self and other health care assistant.		
3. Explain what you are going to do.		
4. Provide privacy.		
5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; lower side rail on side at which you are working.		
6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
7. Move pillow to headboard so client does not hit his/her head when moving up.		
8. Health care assistants should stand on opposite sides of the bed.		
9. Position a draw sheet/folded regular sheet under shoulders and hip area. Each health care assistant should roll edges of sheet toward client's body and grasp rolled sheet with his/her hands at the client's shoulders and at the mid-hip area.		
10. Your feet should be pointed in the direction you are moving the client; bend knees, keep back straight.		
11. On the count of three, each health care assistant lifts the client up off the surface of the bed and toward the head of the bed while shifting weight from back foot to front foot.		
12. Replace pillow.		

13. Adjust backrest for comfort.		
14. Lower bed to a position of safety; raise side rails where ordered.		
15. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
16. Wash your hands.		

The student has satisfactorily completed the procedure "MOVE HELPLESS CLIENT TO HEAD OF BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

MOVE CLIENT TO ONE SIDE OF THE BED

EQUIPMENT:

1. Bed with side rails

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Provide privacy.		
5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; lower side rail on side at which you are working.		
6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
7. Remove pillow and loosen top sheets, but don't expose the client.		
8. Stand on the side of the bed toward which you intend to move client.		
9. Slide both arms under the client's back to his/her far shoulder, then slide the client's shoulders toward you on your arms. NOTE: Keep your knees bent and your back straight as you slide the client.		
10. Slide both your arms as far as you can under the client's buttocks and slide his/her buttocks toward you. Use a lift sheet whenever possible.		
11. Place both your arms under the client's feet and slide them toward you on your arms.		
12. Replace pillows.		
13. Adjust backrest for comfort.		
14. Lower bed to a position of safety; raise side rails where ordered.		

15.	Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
16.	Wash your hands.		

The student has satisfactorily completed the procedure "MOVE CLIENT TO ONE SIDE OF THE BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

TURN CLIENT TO SIDE

EQUIPMENT:

1. Bed with side rails
2. Two pillows - additional blankets/towels as needed
3. Handrail/washcloth

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Provide privacy.		
5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; and lower side rail on side from which you are working.		
6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
7. Loosen the top sheets without exposing the client. Remove pillow.		
8. Check to see that the client has ample space to turn without getting too close to the edge of the bed. If not, have client move over more in bed, or you move the client to the side of the bed that he/she is not turning to.		
9. Cross the client's arms over his/her chest.		
10. Turning client toward you a. Cross the leg farthest from you over the leg closest to you.		
b. Reach across the client and put one hand behind his/her far shoulder.		
c. Place your other hand behind his/her far hip, gently roll him/her toward you.		

	Turning client away from you a. Cross the leg closest to you over the leg farthest from you.		
	b. Place one hand on the client's shoulder near you.		
	c. Put your other hand under client's buttocks, turn him/her gently on his/her side, facing away from you.		
11.	Fold a pillow lengthwise and place it against the client's back for support.		
12.	Support the client's head with the palm of one hand and slide a pillow under his/her head and neck with the other hand.		
13.	Position client's knees slightly flexed, upper leg more than the lower leg. Support upper leg on pillow.		
14.	Support upper arm on pillow.		
15.	Place handroll or rolled washcloth in hand with thumb in opposition to fingers.		
16.	Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
17.	Lower bed to a position of safety; raise side rails where ordered.		
18.	Wash your hands.		

The student has satisfactorily completed the procedure "TURN CLIENT TO SIDE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 40

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:____________

TURN CLIENT TO PRONE POSITION

EQUIPMENT:

1. Bed with side rails
2. Two pillows - additional blankets/towels as needed
3. Handrail/washcloth

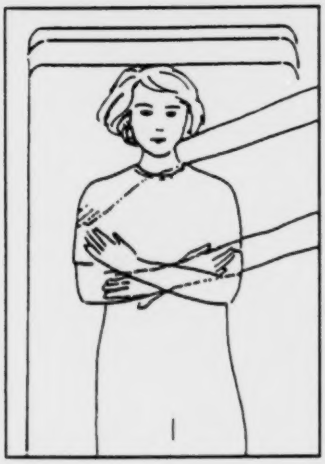
CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Provide privacy.		
5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest; and lower side rail on side from which you are working.		
6. If the client has any tubing coming from his/her body and it is pinned to the bedding, unfasten the tubing so that it will move freely with the client.		
7. Loosen top sheets, do not expose client. Remove pillows.		
8. Move client to side of bed you are on.		
9. Turn client to side.		
10. Move client to side of bed you are on.		
11. Arm near center should be away from body.		
12. Cross upper leg over lower leg.		
13. Roll client onto abdomen.		
14. Place small, firm pillow/folded blanket under the head. Do not use a full pillow as it may cause neck strain and interfere with breathing. CAUTION: Clients can smother if left unsupervised in prone position.		

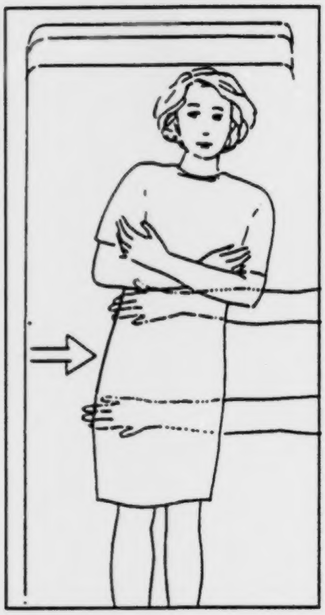
15. Place small, firm pillow under one shoulder.		
16. For female clients, place small, firm pillow under abdomen to prevent pressure on breasts.		
17. Extend feet over end of mattress or slightly elevate feet off mattress by flexing knees and placing pillow under lower legs.		
18. Place handroll or rolled washcloth in hand with thumb in opposition to fingers.		
19. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
20. Lower bed to a position of safety; raise side rails where ordered.		
21. Wash your hands.		

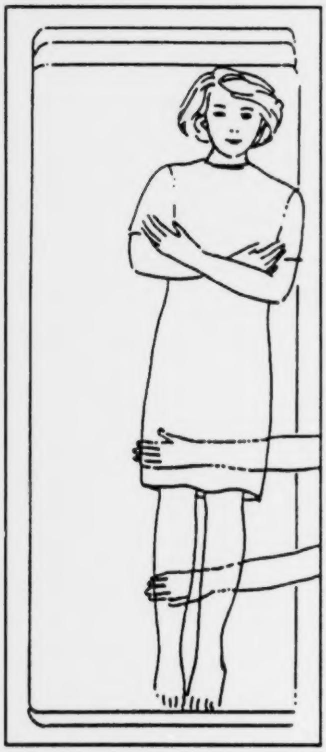
The student has satisfactorily completed the procedure "TURN CLIENT TO PRONE POSITION" according to the steps outlined.

____ ________________
Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

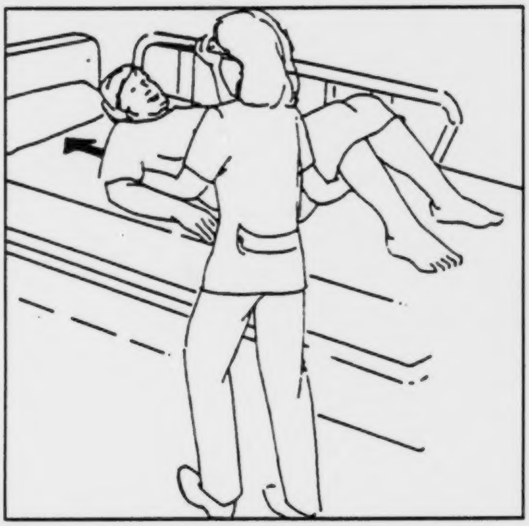
MOVING THE CLIENT IN BED



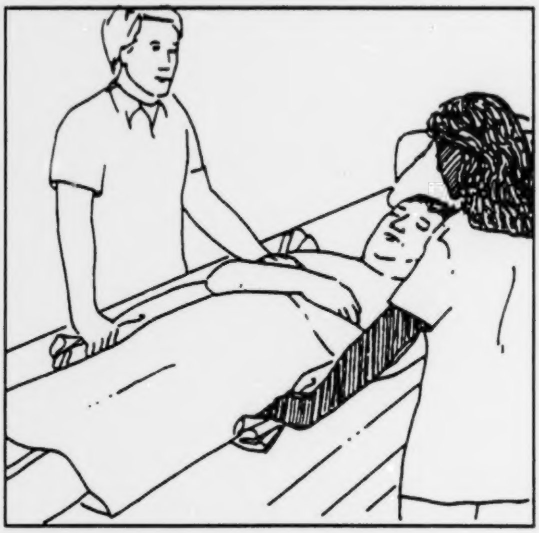




Moving the Client to the Edge of the Bed



Moving the Client Up in Bed



Using a Pull Sheet

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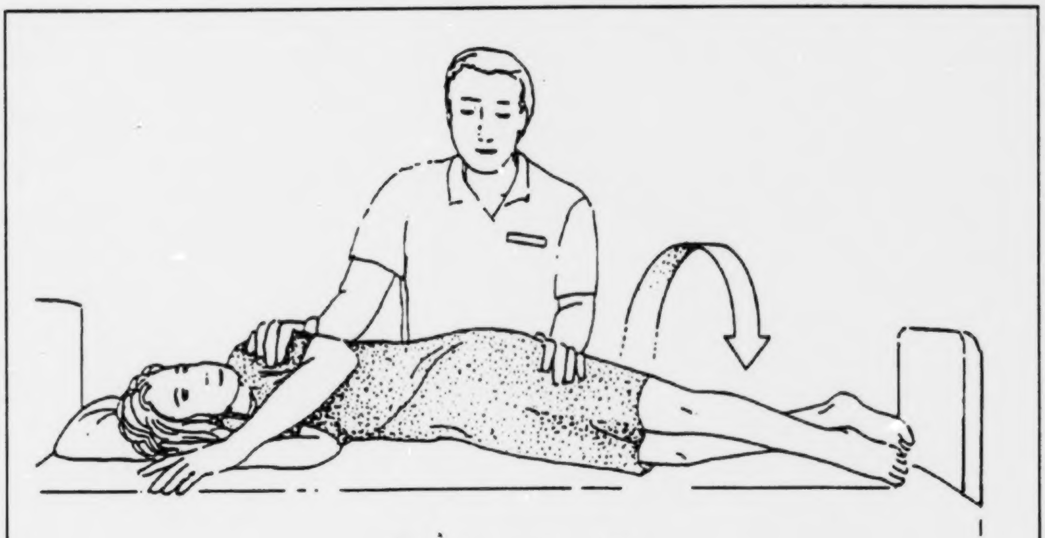
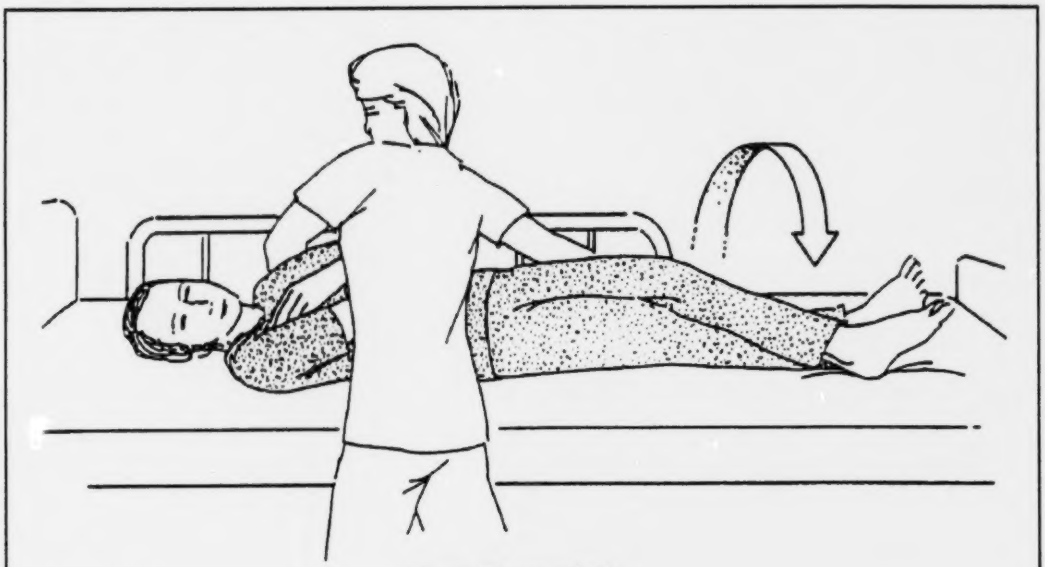
TURNING THE CLIENT



Turn Away from You



Turn Toward You

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LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-41 AND DEMONSTRATION: VIII-41

BED MAKING (UNOCCUPIED/OCCUPIED)
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Identify the difference between an unoccupied bed and an occupied bed.
2. Identify three key points relating to bed making.

Demonstration

3. Make an unoccupied bed according to the steps of procedure.
4. Make an occupied bed according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Making a Mitered Corner and Toe Pleat
2. HO 2: Putting on the Pillowcase
3. Techniques in Bed Making, Video #6, available from the Missouri Vocational Resource Center, 15 min.
4. Television and VCR
5. Pillowcase (bottom of pile)
6. Plastic pillow cover
7. Bedspread

8. Blanket

9. Top sheet

10. Cotton pad or disposable pad (optional)

11. Cotton draw sheet (optional at some facilities)

12. Bottom sheet

13. Mattress pad or cover (top of pile)

14. Linen container

15. Gloves

16. Bath blanket

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 41 (Student Reference page 653) and be prepared to discuss the information presented and return the demonstration of making an unoccupied and occupied bed.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 24.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 19.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 2, Section 5.

INTRODUCTION:

A comfortable, clean, and neatly made bed is extremely important to the elderly. A clean, wrinkle-free bed is especially important for the client on bed rest. This is a simple nursing measure the health care assistant can take to prevent skin breakdown which can lead to decubitus ulcers. In addition, making a bed using the following procedures will make the room appear neat which is important to the clients' feelings about their room. Procedures may vary slightly in facilities depending on type of linens used.

LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

OUTLINE:

I. Difference Between an Unoccupied Bed and an Occupied Bed

   A. An unoccupied bed is made up when the bed is not being used. (II-1)

   B. An occupied bed is made up with the client in it; it is usually part of the complete/partial bed bath.

II. Key Points in Bed Making

   A. Linens should be changed as needed to assure cleanliness. This is usually done on the day when the client has a bath or shower or daily in an acute care facility. (II-2)

   B. Make one side of the bed and then go the other side of the bed to finish the procedure. This saves time and energy.

   C. Remove soiled linens without shaking or coming in contact with the health care assistant's face or uniform. (II-3)

   NOTE: Linens are covered with the client's germs.

   D. Place soiled linens in the proper receptacle--never on the floor or bedside table.

   NOTE: Linens must be bagged at bedside before leaving room.

   E. Check linen for dentures, jewelry, plastic, glasses, disposable pads, face tissues, or anything else before stripping the bed. (II-4)

   F. The bed must be neat and wrinkle free. Wrinkles are uncomfortable and can lead to the development of pressure sores. (II-5)

   G. An incontinent client may have a draw sheet or other protective pads or briefs. Linens should be changed each time they become soiled. (II-6)

   H. Stacking linen in the order used saves time and excess handling of linen. (II-7)

   I. If the client has a foot board, always place linen over the foot board to prevent pressure on the client's feet. (II-8)

   J. If fitted sheets are used, they must be kept securely tucked around the mattress.

III. Demonstrate Procedures for Making Unoccupied and Occupied Beds.

IV. Summary and Conclusion

  A. Difference between an unoccupied bed and an occupied bed

  B. Key points in bed making

  C. Review procedures for making unoccupied and occupied beds.

In this lesson you have applied correct body mechanics in performing the bed making procedure. The next lesson is ambulation of the clients.

LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

STEPS OF PROCEDURE FOR MAKING AN UNOCCUPIED BED:

1. Wash your hands. Put on gloves.

2. Arrange necessary linens in order to be used.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Raise bed to high position; lower bed rails.

   NOTE: Bed should be in flat position.

6. Remove pillow and strip pillowcase.

7. Strip bed and place soiled linen in linen container.

8. Wash and dry mattress, if soiled.

9. Remove gloves and dispose in appropriate container.

10. Wash hands.

11. Place mattress pad on bed and pull smooth.

12. Unfold bottom sheet on bed, full length, with bottom hem at bottom edge of mattress.

    NOTE: For fitted sheets, tuck in both sides of mattress pad and make sure all four corners are fitted securely under the corners.

13. Tuck in head end of bottom sheet and miter corner. (HO 1)

14. Tuck in near edge of bottom sheet, working from head to foot.

15. Folding plastic draw sheet in half, place on middle 1/3 of mattress; tuck in near side only.

16. Folding cotton draw sheet in half, place over plastic draw sheet and tuck near side only.

17. Place top sheet, halved, full length of bed, with hem at edge of head end of mattress.

18. Unfold the top sheet and place it level with the top edge of the head of the mattress.

19. Place blanket over top sheet centered on bed and about eight (8) inches down from the edge of the top sheet.

20. Place bedspread (centered) over top sheet and blanket, leave enough spread to cover a pillow at top edge.

21. Miter lower corner of sheet, blanket, and spread together on near side; allow to hang free.

22. Gather open end of pillowcase in one hand, full length, and grasp pillow edge with same hand; with free hand fit pillow corners into case. (HO 2)

23. Place pillow on near half of bed with open end of case away from the doorway; walk to far side of bed.

24. Fold back on bed each piece of linen.

25. Pull mattress pad smooth and tuck under mattress from head to foot.

26. Pull bottom sheet tight; tuck under head of mattress; miter corner; tuck in remainder of sheet from head to foot.

27. Tighten plastic draw sheet; tuck in middle first, then top 1/3, and finally bottom 1/3.

28. Repeat step 27 with cotton draw sheet.

29. Pull top sheet, blanket, and bedspread straight; tuck under foot end of mattress.

30. Miter corner with sheet, blanket, and spread.

31. Place pillow in center of head of bed; pull bedspread over.

32. Lower bed and recess bed cranks.

33. Raise bed rail on opposite side of entry.

34. Place call signal within the client's reach.

STEPS OF PROCEDURE FOR MAKING AN OCCUPIED BED:

1. Wash your hands. Put on gloves.

2. Arrange necessary linens in order to be used.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.
6. Raise bed to comfortable working position, side rails up unless you are working on that side.
7. Lower back and knee rest until bed is flat, if client's condition allows.
8. Loosen the top of bedding at foot of bed.
9. Remove spread; fold spread to foot of bed; remove by grasping center; place on back of chair.
10. Remove blanket according to above procedure.
11. Place bath blanket over top sheet. Ask client to hold blanket in place or tuck under client's shoulders. Remove top sheet and place in linen container.
12. Keep pillow under client's head and turn client to side of bed you are not making.
13. Loosen bottom bedding; free bottom linen and roll each piece to the client's back.
14. Remove gloves and dispose in appropriate container.
15. Wash hands.
16. Place mattress pad on bed lengthwise with fold in the center.
17. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.
18. Tuck sheet under head of mattress, miter corners; tuck well under side of mattress.
19. Fanfold bottom sheet close to client's back.
20. Place draw sheet or protective pad on middle 1/3 of mattress; fanfold 1/2 to client's back and tuck in near side only.
21. Center draw sheet; fanfold one-half to client's back; tuck other end under mattress.
22. Raise bed side rail; assist client in turning and moving to clean side of bed.
23. Move and keep pillow under client's head.
24. Go to opposite side of bed; lower bed side rail.
25. Pull through all bottom linen; remove and discard soiled linen in linen container.
26. Pull clean mattress pad toward edge of bed - tuck under mattress.

27. Pull clean bottom sheet toward the edge of bed. Tuck it under the mattress at the head of the bed and make a mitered corner.

28. Pull the sheet toward foot of bed and tuck under mattress.

29. Pull draw sheet or protective pad, tighten, and tuck under the mattress.

30. Assist client to center of bed.

31. Place top sheet over bath blanket; ask client to hold or tuck under client's shoulders.

32. Remove bath blanket and place in linen container.

33. If blanket is used, place over top sheet; place bedspread over blanket even with top sheet.

34. Make tuck in top linen at foot of bed.

    NOTE: Make toe pleat by folding over two (2) inches where feet are. (HO 1)

35. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side.

36. Change pillowcase and place pillow under client's head. (HO 2)

37. Lower bed and recess bed cranks.

38. Both side rails should be up.

39. Place call signal within reach.

40. Take bagged dirty linen to appropriate container.

41. Wash your hands.

LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. What is the difference between an unoccupied bed and an occupied bed?
2. When should linens be changed?
3. Why should soiled linens be removed without shaking or coming in contact with the health care assistant's face?
4. What are linens checked for before stripping the bed?
5. What is the significance of a clean, wrinkle-free bed for the client?
6. How often do you change the bed linen of the incontinent client?
7. Why is linen stacked in the order of use?
8. When using a footboard, how would you place the top sheet, blanket, and spread?
9. Why is it important to complete as much as possible on one side of the bed before going to the other side?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisuals.
2. Instructor demonstrates unoccupied bed making procedure.
3. Students practice unoccupied bed making procedure.
4. Instructor demonstrates occupied bed making procedure.
5. Students practice occupied bed making procedure.

ANSWERS TO EVALUATION ITEMS:

1. b
2. a
3. c
4. d
5. b

6. c
7. b
8. a
9. b
10. c
11. c
12. b
13. c
14. d

LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

1. An occupied bed is made up: (Circle the letter of the best answer.)
   a. With the top sheet pulled to the head of the bed.
   b. With the client in it.
   c. When the bed is not in use.
   d. With the bottom linens only.

2. How often are linens changed? (Circle the letter of the best answer.)
   a. As needed to assure cleanliness
   b. Only when they have stool on them
   c. Once weekly
   d. Only when they are wet

3. When linens are removed from the bed, they should be removed and: (Circle the letter of the best answer.)
   a. Placed on the floor.
   b. Shook to make certain no valuables are in them.
   c. Should not contact the health care assistant's face or uniform.
   d. Placed on the bedside table after shaking them.

4. What should the health care assistant do before stripping the bed of linen: (Circle the letter of the best answer.)
   a. Ask the client if he/she wants the bed changed.
   b. Ask another co-worker to assist with making the bed.
   c. Check if the bed really needs to be changed.
   d. Check linen for dentures, jewelry, glasses, and other items.

5. Why should you remove all wrinkles from the sheets when making an occupied bed? (Circle the letter of the best answer.)
   a. Wrinkles do not look nice.
   b. Wrinkles are uncomfortable and cause pressure sores.
   c. Wrinkles collect more germs and infection.
   d. Visitors are upset if they see wrinkled sheets.

6. Linens of an incontinent client are changed: (Circle the letter of the best answer.)

   a. Daily.
   b. When the bath is given.
   c. Anytime they are soiled.
   d. Three to four times a week.

7. The purpose of stacking linens in the order of use is: (Circle the letter of the best answer.)

   a. To make the room look neat.
   b. To save time and excessive handling.
   c. To prevent any linen from being lost.
   d. To keep your instructor happy.

8. If a client has a foot board, the linens should be placed: (Circle the letter of the best answer.)

   a. Over the foot board.
   b. Under the foot board.
   c. Under the mattress at the foot of the bed.
   d. The same way as when making any other bed.

9. Soiled linens should be placed: (Circle the letter of the best answer.)

   a. On the floor.
   b. In the linen container.
   c. On the bedside table.
   d. On the chair.

10. The correct procedure for making an unoccupied bed, is to make the: (Circle the letter of the best answer.)

    a. Far side of the bottom sheet first.
    b. Near side of the entire bed first.
    c. Far side of the entire bed first.
    d. Entire bottom first.

11. The correct procedure for placing a pillow case on the pillow is to: (Circle the letter of the best answer.)

    a. Hold the pillow under your chin.
    b. Lay the pillow on a chair.
    c. Pull the case over while grasping the pillow with the other hand.
    d. Lay the pillow on the bedside stand and pull the case over the pillow.

12. When placing the top sheet on an unoccupied bed, the corners at the foot of the bed should be: (Circle the letter of the best answer.)

    a. Fan folded toward the head of bed.
    b. Mitered to fit properly.
    c. Hung loosely over the edge.
    d. Folded so the edge is on top of the mattress.

13. Changing the bed linen of an occupied bed is easiest for you and most comfortable for the client when you: (Circle the letter of the best answer.)

    a. Make the bed from bottom to top.
    b. Change both sides of the bottom linen first.
    c. Change one complete side then the other side.
    d. Elevate the head of the bed 45°.

14. The top sheet is made with a toe pleat to: (Circle the letter of the best answer.)_

    a. Give a better appearance to the bed.
    b. Prevent the linens from slipping.
    c. Prevent wrinkles from forming.
    d. Prevent pressure on the client's toes.

LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ________________

MAKE AN UNOCCUPIED BED

EQUIPMENT:

1. Pillowcase
2. Plastic pillow cover
3. Bedspread
4. Blanket
5. Top sheet
6. Cotton pad or disposable pad (optional)
7. Cotton draw sheet
8. Plastic or rubber draw sheet
9. Bottom sheet
10. Mattress pad or cover
11. Linen container
12. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Arrange necessary linens in order to be used.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Raise bed to high position; lower bed rails. NOTE: Bed should be in flat position.		
6. Remove pillow and strip pillowcase.		
7. Strip bed and place soiled linen in linen container.		
8. Wash and dry mattress if soiled.		
9. Remove gloves and dispose in appropriate container.		
10. Wash hands.		
11. Place mattress pad on bed and pull smooth.		
12. Unfold bottom sheet on bed, full length, with bottom hem at bottom edge of mattress. NOTE: For fitted sheets, tuck in both sides of mattress pad and made sure all four corners are fitted securely under the corners.		
13. Tuck in head end of bottom sheet and miter corner.		
14. Tuck in near edge of bottom sheet, working from head to foot.		
15. Folding plastic draw sheet in half, place on middle 1/3 of mattress; tuck in near side only.		

16.	Folding cotton draw sheet in half, place over plastic draw sheet and tuck near side only.		
17.	Place top sheet, halved, full length of bed, with hem at edge of head end of mattress.		
18.	Unfold the top sheet and place it level with the top edge of the head of the mattress.		
19.	Place blanket over top sheet centered on bed and about eight (8) inches down from the edge of the top sheet.		
20.	Place bedspread (centered) over top sheet and blanket; leave enough spread to cover a pillow at top edge.		
21.	Miter lower corner of sheet, blanket, and spread together on near side; allow to hang free.		
22.	Gather open end of pillowcase in one hand, full length, and grasp pillow edge with same hand; with free hand fit pillow corners into case.		
23.	Place pillow on near half of bed with open end of case away from the doorway; walk to far side of bed.		
24.	Fold back on bed each piece of linen.		
25.	Pull mattress pad smooth and tuck under mattress from head to foot.		
26.	Pull bottom sheet tight; tuck under head of mattress; miter corner; tuck in remainder of sheet from head to foot.		
27.	Tighten plastic draw sheet; tuck in middle first, then top 1/3, and finally bottom 1/3.		
28.	Repeat step 27 with cotton draw sheet.		
29.	Pull top sheet, blanket, and bedspread straight; tuck under foot end of mattress.		
30.	Miter corner with sheet, blanket, and spread.		
31.	Place pillow in center of head of bed; pull bedspread over.		
32.	Lower bed and recess bed cranks.		
33.	Raise bed rail on opposite side of entry.		
34.	Place call signal within the client's reach.		

The student has satisfactorily completed the procedure "MAKE AN UNOCCUPIED BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 41

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

MAKE AN OCCUPIED BED

EQUIPMENT:

1. Pillowcase
2. Plastic pillow cover
3. Bedspread
4. Blanket
5. Top Sheet
6. Cotton pad or disposable pad (optional)
7. Cotton draw sheet
8. Plastic or rubber draw sheet
9. Bottom sheet
10. Mattress pad or cover
11. Linen container
12. Bath blanket
13. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING		YES	NO
1.	Wash your hands. Put on gloves.		
2.	Arrange necessary linens in order to be used.		
3.	Identify and greet client. Identify self.		
4.	Explain what you are going to do.		
5.	Provide privacy.		
6.	Raise bed to comfortable working position; side rails up unless you are working on that side.		
7.	Lower back and knee rest until bed is flat, if client's condition allows.		
8.	Loosen the top of bedding at foot of bed.		
9.	Remove spread; fold spread to foot of bed; remove by grasping center; place on back of chair.		
10.	Remove blanket according to above procedure.		
11.	Place bath blanket over top sheet. Ask client to hold blanket in place or tuck under client's shoulders. Remove top sheet and place in linen container.		
12.	Keep pillow under client's head and turn client to side of bed you are not making.		
13.	Loosen bottom bedding; free bottom linen and roll each piece to the client's back.		

14. Remove gloves and dispose in appropriate container.		
15. Wash hands.		
16. Place mattress pad on bed lengthwise with fold in the center.		
17. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.		
18. Tuck sheet under head of mattress; miter corners; tuck well under side of mattress.		
19. Fanfold bottom sheet close to client's back.		
20. Place draw sheet or protective pad on middle 1/3 of mattress; fanfold 1/2 to client's back and tuck in near side only.		
21. Center draw sheet; fanfold one-half to client's back; tuck other end under mattress.		
22. Raise bed side rail; assist client in turning and moving to clean side of bed.		
23. Move and keep pillow under client's head.		
24. Go to opposite side of bed; lower bed side rail.		
25. Pull through all bottom linen; remove and discard soiled linen in linen container.		
26. Pull clean mattress pad toward edge of bed; tuck under mattress.		
27. Pull clean bottom sheet toward the edge of bed. Tuck it under the mattress at the head of the bed and make a mitered corner.		
28. Pull the sheet toward foot of bed and tuck under mattress.		
29. Pull draw sheet or protective pad, tighten, and tuck under the mattress.		
30. Assist client to center of bed.		
31. Place top sheet over bath blanket; ask client to hold or tuck under client's shoulders.		
32. Remove bath blanket and dispose in linen container.		
33. If blanket is used, place over top sheet; place bedspread over blanket even with top sheet.		
34. Make tuck in top linen at foot of bed. NOTE: Make toe pleat by folding over two (2) inches where feet are.		
35. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side.		

36. Change pillowcase and place pillow under client's head.		
37. Lower bed and recess bed cranks.		
38. Both side rails should be up.		
39. Place call signal within reach.		
40. Take bagged dirty linen to appropriate container.		
41. Wash your hands.		

The student has satisfactorily completed the procedure "MAKE AN OCCUPIED BED" according to the steps outlined.

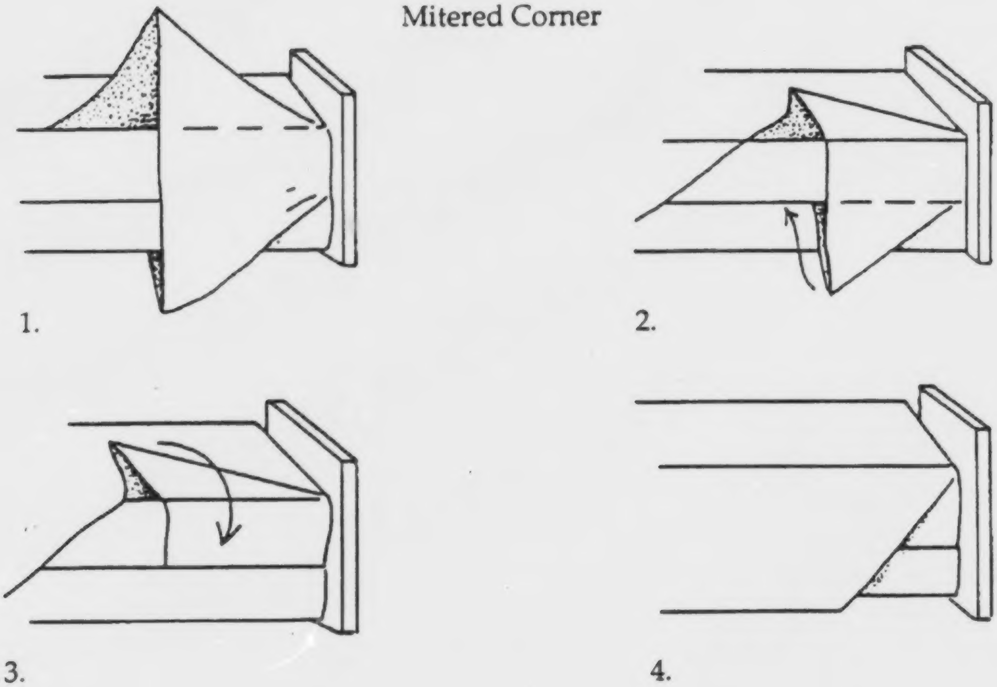
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

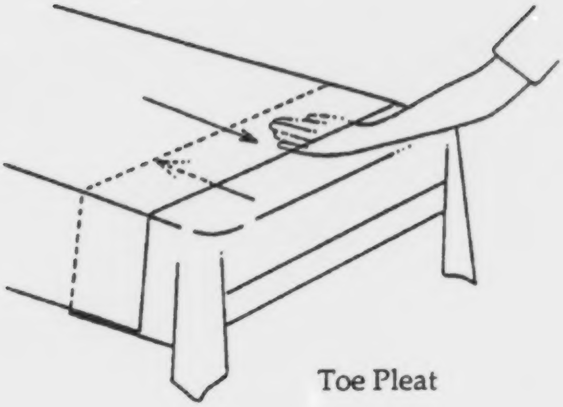
Date

HO 1

MAKING A MITERED CORNER AND TOE PLEAT

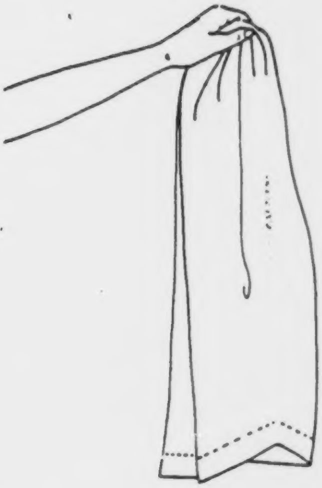
Mitered Corner



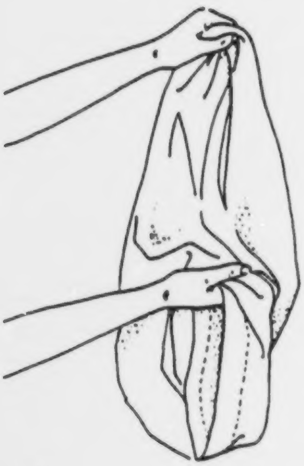


Toe Pleat

PUTTING ON THE PILLOWCASE



A.



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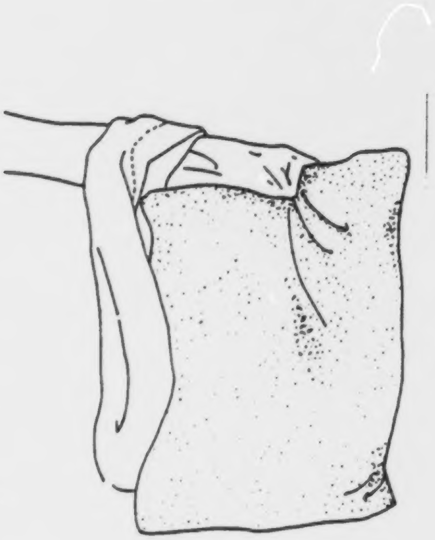

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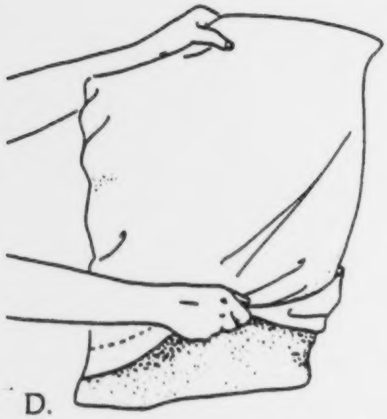

D.

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-42 AND DEMONSTRATION: VIII-42

AMBULATION
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. List three purposes of ambulation.
2. List reasons why the elderly may need assistance in ambulating.
3. Identify nursing responsibilities when assisting the client with ambulation.
4. Describe the purpose of equipment that may be used to assist with ambulating a client.
5. Identify correct procedure when using equipment to assist the client to ambulate.

Demonstration

6. Ambulate client using a gait belt according to the steps of procedure.
7. Ambulate client using a walker according to the steps of procedure.
8. Ambulate client using a cane according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Gait belt
2. Walker
3. Cane

4. Brace

5. Prosthesis

6. HO 1: Use of Gait Belt During Ambulation

7. HO 2: Walkers

8. HO 3: Canes

9. Exercise Techniques, video #11, available from the Missouri Vocational Resource Center, 16 min.

10. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 42 (Student Reference page 667) prior to class and be prepared to discuss the information presented and return the demonstrations of ambulating clients using various equipment.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 28.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 13, Section 5.

Sorrentino, Sheila, Mosby's Textbook for Nursing Assistants, 3rd ed. St. Louis, MO Mosby, 1992, Chapter 18.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 8, Section 2.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 7.

INTRODUCTION:

Ambulation means walking or moving around in an upright position. Ambulating a client correctly is a skill that a health care assistant must develop in order to help the client remain physically active and to prevent complications of extended bed rest. Clients may fall when ambulating because they are weak, lightheaded, or dizzy. Falling can also occur because of waxed floors, spills, or improperly fitting shoes. Remember if a client begins to fall, always ease him/her to the floor. Any time the elderly needs assistance with ambulation in long-term care, you should use a gait belt.

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

OUTLINE:

I. Purposes of Ambulation

- A. Keeps the client more active (II-1)
- B. Improves muscle tone in legs; improves strength
- C. Provides sense of accomplishment
- D. Allows client to maintain greater independence

II. Reasons Why the Elderly Client May Need Assistance With Ambulation - aging changes may cause: (II-2)

- A. Decreased muscle strength
- B. Changes of the center of gravity and posture
- C. Decreased sensory perception
- D. Impaired balance
- E. Confusion
- F. Drugs which the elderly client is receiving
- G. Distractions
- H. Drop attacks - falls for no reason other than a sudden loss of muscle tone in the legs

III. Health care assistant Responsibilities in Ambulating Clients

- A. Be aware of safety considerations - make sure objects and other clients are out of the way; no slippery floors or shoes; suction tips on all equipment.
- B. Use good body mechanics.
- C. Dress client appropriately. Client should wear stockings and nonskid shoes to prevent falls. (II-3)

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D. Observe client's ambulation and response to ambulation (e.g., steadiness of gait, balance, and endurance).

E. Ambulate client in an uncluttered area. Have a chair ready for the client at the other end or at a resting point along the way.

F. Most of the time, you will ambulate at the client's side, with your arm/hand for support--standing on the client's stronger side. If the client is to be encouraged to use a weak leg, stand on the weak side. **(II-4)**

G. Allow client to sit on side of bed before ambulating to allow time for client to gain balance.

H. As you walk with the client, observe for signs of fatigue such as difficult breathing, sweating, dizziness, and rapid heart beat. If these occur, allow the client to rest. **(II-5)**

I. If client loses weight-bearing ability, pull the client's body into close alignment with your hip/thigh area by using the gait belt and lower to floor using large muscles of your legs. **(II-6)**

J. In a long-term care facility, encourage clients to use the handrail in the hall.

IV. Equipment Used for Ambulation **(II-7)**

A. Transfer or gait belt (HO 1)

1. Grasp the belt with both hands and use it to guide the client. Your hands should be under the gait belt. **(II-8)**

2. Walk slowly and allow the client to set the pace.

3. Walk with the client by placing one hand in front of his/her waist and the other hand in back under the gait belt; walk on the weakest side and encourage client to hold handrail, if available, with strong arm.

B. Walker (HO 2)

1. It is used for client who requires some support when walking due to imbalance or weakness.

2. Client may be able to bear weight on one foot, remain balanced in an upright position, and have use of hands and arms.

3. When walker without wheels is being moved, the client's feet should not be moving. It should never be slid along the floor or ground. Always instruct the client to move the walker forward by lifting it up. **(II-9)**

4. The height of the walker should be adjusted so that the client is standing straight with elbows slightly flexed.

5. Check rubber tips frequently on walkers that do not have wheels.

C. Cane (HO 3)

1. It is used for clients who have weakness or paralysis on one side of the body.

2. It should be used on client's stronger side to balance his/her weight between the cane and his/her weaker side. **(II-10)**

3. The height of the cane should be such that the client holds it with his/her elbow slightly bent when walking.

4. Three-point and four-point canes give more support than single tip canes, but they are harder to move.

5. The tip of the cane should be about six to ten inches to the side of the foot.

6. The handle is level with the hip.

7. When the client walks, the cane is moved first about 12 inches. **(II-11)**

D. Brace

1. It is used for the client who needs specific support for weakened muscles/joints or to provide immobilization of an injured part. **(II-12)**

2. Never loosen screws/bolts of brace. Check skin where brace is applied for any signs of breakdown.

3. Prop brace when not in use. Never lay it flat--it could warp.

E. Prosthesis - artificial limb

1. It is used for the client who is missing an arm/leg.

2. Check skin of stump for any signs of breakdown; see that prosthesis fits.

V. Demonstrate Procedures for Ambulating Client.

VI. Summary and Conclusion

A. Purposes of ambulation

B. Reasons why clients may need assistance with ambulation

C. Health care assistant's responsibilities in ambulating clients

D. Equipment used for ambulation

E. Review procedures for ambulating client.

This lesson has included principles and the procedures for ambulating a client. The next lesson will be transferring clients.

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

STEPS OF PROCEDURE FOR AMBULATION WITH A GAIT BELT:

1. Wash your hands.
2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Lower bed to lowest level; assist client to sit on edge of bed.
5. Pause and allow client to sit on edge of bed a few moments to regain balance.
6. Assist client in putting on nonskid shoes and socks.
7. Put gait belt around client's waist.
8. Stand in position of good body mechanics.
9. Assist the client to a standing position by grasping belt on either side as he/she puts his/her hands on your upper arms.
10. Assist client to stand by straightening legs as you lift with gait belt as client pushes down with hands on the mattress.
11. Pause to allow client to regain balance.
12. Walk with the client by placing one arm in front of his/her waist and the other hand in back under the gait belt. Walk on the weakest side and encourage client to hold handrail, if available, with strong arm.
13. Walk in the same pattern as the client (both step with left foot at the same time). Assist client to step forward with strong foot first.
14. Walk client the distance instructed by charge nurse.

    NOTE: If client loses weight-bearing ability, pull the client's body into close alignment with your hip/thigh area by using the gait belt and lower to floor using large muscles of your legs.

15. Return client to bed/chair.
16. Make sure client is comfortable; place call signal within reach.

17. Remove gait belt.

18. Wash your hands.

19. Record observations.

STEPS OF PROCEDURE FOR AMBULATION WITH WALKER:

1. Wash your hands.

2. Identify and greet client. Identify self.

3. Explain what you are going to do.

4. Lower bed to lowest level; assist client to sit on edge of bed.

5. Pause and allow client to sit on edge of bed a few moments to regain balance.

6. Assist client in putting on nonskid shoes and socks.

7. Apply gait belt.

8. Stand in position of good body mechanics.

9. Assist the client to a standing position.

10. Instruct client to position body within the frame of the walker.

11. Instruct client to move walker forward by lifting it up.

12. Instruct client to take a step forward with the weak leg.

13. Instruct client to move strong leg forward.

14. Walk client the distance instructed by charge nurse.

15. Return client to bed or chair. To ambulate backward, client steps back with strong foot, takes a step back with weak foot, then walker is moved back. Have client feel for arm of chair or top of mattress with his/her hand.

16. Make sure client is comfortable; place call signal within reach.

17. Wash your hands.

18. Record observations.

STEPS OF PROCEDURE FOR AMBULATION WITH CANE:

1. Wash your hands.

2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Lower bed to lowest level; assist client to sit on edge of bed.
5. Pause and allow client to sit on edge of bed a few moments to regain balance.
6. Assist client in putting on nonskid shoes and socks.
7. Apply gait belt.
8. Stand in position of good body mechanics.
9. Assist the client to a standing position.
10. Instruct client to take short steps and keep head up and eyes looking forward.
11. Instruct client to move cane forward and a little out to the side of the strong leg.
12. Instruct client to move weak extremity forward to line up evenly with tip of cane just after cane is placed.
13. Instruct client to put weight on cane and weak foot while swinging strong foot forward, taking a step.
14. Walk in the same pattern as the client (both step with left foot at the same time).
15. Walk client the distance instructed by charge nurse.
16. Return client to bed/chair.
17. Make sure client is comfortable; place call signal within reach.
18. Wash your hands.
19. Record observations.

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. Why is it important to ambulate the client?
2. Why might a client need assistance in ambulating?
3. Why does the client need stockings and nonskid shoes in order to prepare for ambulation?
4. Where should you walk when ambulating a client?
5. What should you do if a client becomes dizzy and weak while you are walking him/her?
6. What is the procedure for lowering a client to the floor if he/she loses his/her weight-bearing ability?
7. What are four types of equipment that can be used to assist the client with ambulation?
8. Where are the health care assistant's hands placed when walking a client with a gait belt?
9. How should the client be instructed to move the walker forward?
10. On which side should the client hold the cane?
11. How many inches from the side of the foot should the cane be placed?
12. When is a walker, a cane, a brace, or a prosthesis used?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates ambulation procedures using gait belt, walker, and cane.
2. Students practice ambulating one another with gait belt, walker, and cane.
3. Show video.

ANSWERS TO EVALUATION ITEMS:

1. The student may list any three of the following:
   a. Keeps the client more active
   b. Improves muscle tone in legs; improves strength
   c. Provides sense of accomplishment
   d. Allows client to maintain greater balance

2. a
3. d
4. d
5. c
6. c
7. b
8. d
9. d
10. c
11. d

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

1. List three purposes of ambulation:

   a.

   b.

   c.

2. What is one reason a client may need assistance with ambulation? (Circle the letter of the best answer.)

   a. Drop attacks
   b. Eye glasses
   c. Hearing aids
   d. Attention

3. When ambulating a client, it is the health care assistant's responsibility to: (Circle the letter of the best answer.)

   a. Make certain the client is wearing house slippers.
   b. Stand on the client's good side if he/she is encouraged to use the weak leg.
   c. Hold the client up if he/she loses balance.
   d. Stand on the client's stronger side.

4. Which of the following is NOT a device used to assist with ambulation? (Circle the letter of the best answer.)

   a. Walker
   b. Cane
   c. Gait belt
   d. Wheelchair

5. As you are walking Mrs. Smithers in the hall, you notice she is sweating and is having difficulty breathing. Plus, she complains of dizziness. Which one of the following would be the first most appropriate action for you to take? (Circle the letter of the best answer.)

   a. Go for the charge nurse and ask her to check Mrs. Smithers.
   b. Hurry up and get Mrs. Smithers back to her room and in bed.
   c. Stop walking Mrs. Smithers, stay with her, and allow her to rest.
   d. Call for another co-worker to come and help you hold Mrs. Smithers upright.

6. Mr. Green begins to fall. What is the first thing you should do? (Circle the letter of the best answer.)

   a. Grab Mr. Green to prevent the fall.
   b. Hold Mr. Green up with the gait belt.
   c. Ease Mr. Green to the floor.
   d. Get out of the way to prevent injury to yourself.

7. When using a transfer or gait belt, you should: (Circle the letter of the best answer.)

   a. Grasp the belt with your left hand, leaving your right hand free if the client falls.
   b. Walk with the client by placing one hand in front of his/her waist and the other hand in back under the gait belt.
   c. Encourage the client to hold the handrail with the weak arm and put the strong arm around your neck.
   d. Walk with the client by placing one hand under his/her axilla and the other hand under the gait belt in front.

8. When a walker without wheels is being moved, the client should be instructed to: (Circle the letter of the best answer.)

   a. Move his/her feet at the same time as the walker.
   b. Slide the walker along the floor.
   c. Keep elbows straight.
   d. Move the walker forward by lifting it.

9. When a client walks with a cane, the cane is held on: (Circle the letter of the best answer.)

   a. Either side.
   b. The weak side.
   c. Both sides.
   d. Strong side.

10. The cane should be how many inches from the side of the foot? (Circle the letter of the best answer.)

   a. Two to four inches
   b. Twelve to fifteen inches
   c. Six to ten inches
   d. One to three inches

11. A brace is used when the client: (Circle the letter of the best answer.)

   a. Needs specific support for weakened muscles/joints or to provide. immobilization of an injured part.
   b. Is missing an arm or leg.
   c. Has weakness or paralysis on one side of the body.
   d. Requires some support when walking due to imbalance or weakness.

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

AMBULATE CLIENT USING GAIT BELT

EQUIPMENT:

1. Gait belt

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Lower bed to lowest level; assist client to sit on edge of bed.		
5. Pause and allow client to sit on edge of bed a few moments to regain balance.		
6. Assist client in putting on nonskid shoes and socks.		
7. Put gait belt around client's waist.		
8. Stand in position of good body mechanics.		
9. Assist the client to a standing position by grasping belt on either side as he/she puts his/her hands on your upper arms.		
10. Assist client to stand by straightening legs as you lift with gait belt as client pushes down with hands on the mattress.		
11. Pause to allow client to regain balance.		
12. Walk with the client by placing one arm in front of his/her waist and the other hand in back under the gait belt. Walk on the weakest side and encourage client to hold handrail, if available, with strong arm.		
13. Walk in the same pattern as the client (both step with left foot at the same time). Assist client to step forward with strong foot first.		

14.	Walk client the distance instructed by charge nurse. NOTE: If client loses weight-bearing ability, pull the client's body into close alignment with your hip/thigh area by using the gait belt and lower to floor using large muscles of your legs.		
15.	Return client to bed/chair.		
16.	Make sure client is comfortable; place call signal within reach.		
17.	Remove gait belt.		
18.	Wash your hands.		
19.	Record observations.		

The student has satisfactorily completed the procedure "AMBULATE CLIENT WITH GAIT BELT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

AMBULATE CLIENT USING WALKER

EQUIPMENT:

1. Walker
2. Gait belt

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Lower bed to lowest level; assist client to sit on edge of bed.		
5. Pause and allow client to sit on edge of bed a few moments to regain balance.		
6. Assist client in putting on nonskid shoes and socks.		
7. Apply gait belt.		
8. Stand in position of good body mechanics.		
9. Assist the client to a standing position.		
10. Instruct client to position body within the frame of the walker.		
11. Instruct client to move walker forward by lifting it up.		
12. Instruct client to take a step forward with the weak leg.		
13. Instruct client to move strong leg forward.		
14. Walk client the distance instructed by charge nurse.		
15. Return client to bed or chair. To ambulate backward, client steps back with strong foot, takes a step back with weak foot, then walker is moved back. Have client feel for arm of chair or top of mattress with his/her hand.		
16. Make sure client is comfortable; place call signal within reach.		
17. Wash your hands.		

18. Record observations.		

The student has satisfactorily completed the procedure "AMBULATE CLIENT USING WALKER" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 42

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

AMBULATE CLIENT USING CANE

EQUIPMENT:

1. Cane
2. Gait belt

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Lower bed to lowest level; assist client to sit on edge of bed.		
5. Pause and allow client to sit on edge of bed a few moments to regain balance.		
6. Assist client in putting on nonskid shoes and socks.		
7. Apply gait belt.		
8. Stand in position of good body mechanics.		
9. Assist the client to a standing position.		
10. Instruct client to take short steps and keep head up and eyes looking forward.		
11. Instruct client to move cane forward and a little out to the side of the strong leg.		
12. Instruct client to move weak extremity forward to line up evenly with tip of cane just after cane is placed.		
13. Instruct client to put weight on cane and weak foot while swinging strong foot forward, taking a step.		
14. Walk in the same pattern as the client (both step with left foot at the same time).		
15. Walk client the distance instructed by charge nurse.		
16. Return client to bed/chair.		

17.	Make sure client is comfortable; place call signal within reach.		
18.	Wash your hands.		
19.	Record observations.		

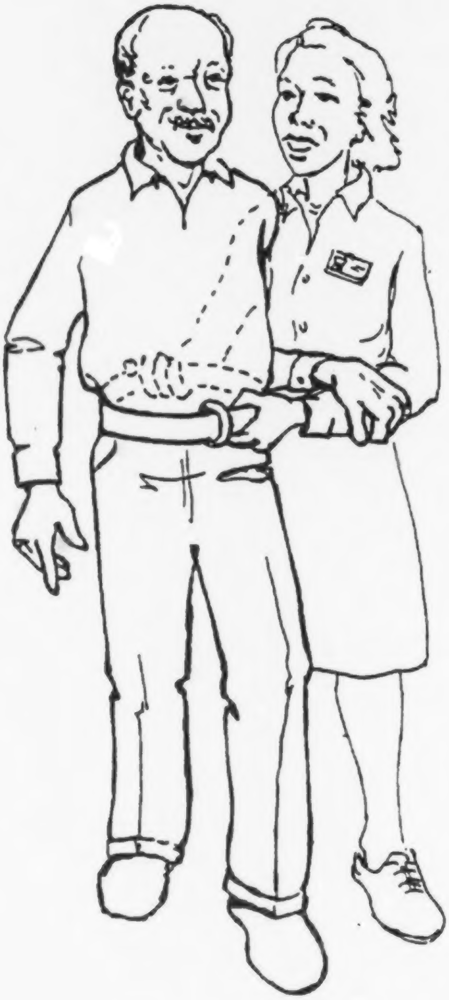
The student has satisfactorily completed the procedure "AMBULATE CLIENT USING CANE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

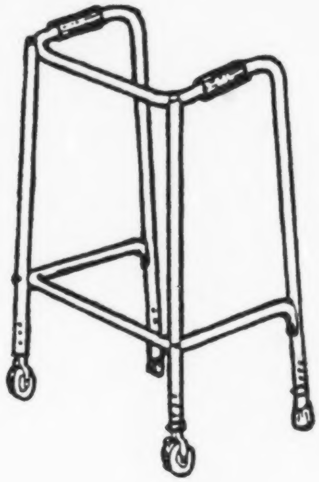
Date

HO 1

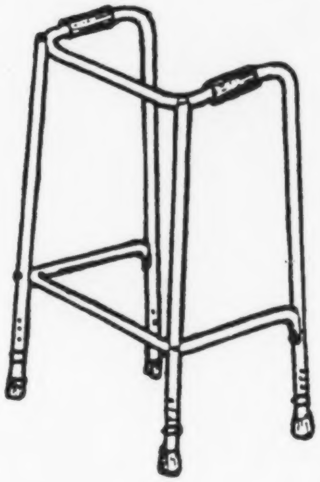
USE OF GAIT BELT DURING AMBULATION



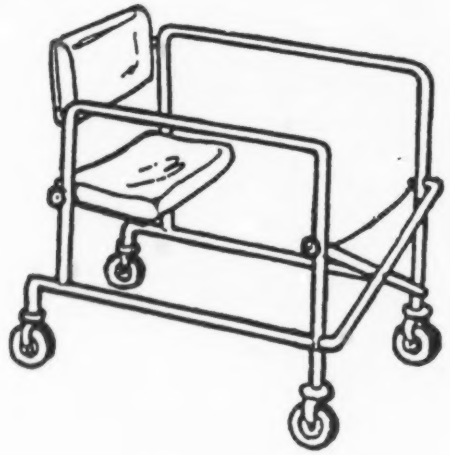
WALKERS



Rolling Walker



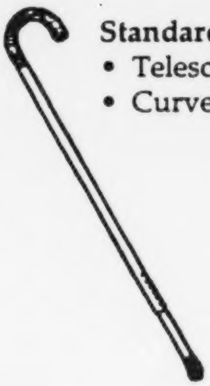
Standard Pick-Up Walker



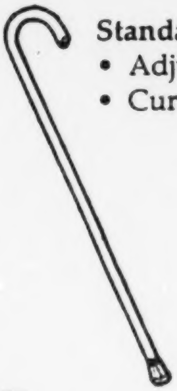
Wheeled Walker

- Requires partial strength of hands and wrists
- Requires strong elbow extensors and shoulder depressors

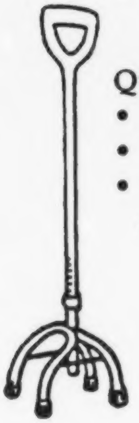
CANES



Standard Aluminum Cane
- Telescoping feature allows for adjustment
- Curved handle for better grip



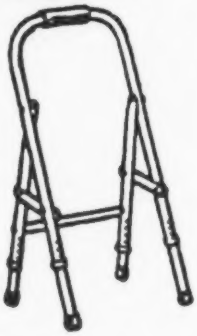
Standard Wooden Cane
- Adjusted by cutting to desired length
- Curved handle for better grip



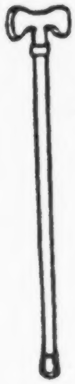
Quad Cane
- Adjustable length
- Four leg contacts with floor
- Gives more support as long as all tips contact floor

Ortho-Cane
- Places weight under resident's hand
- Greater balance and control
- Can use ortho-grip

Functional Grip Canes



Walk Cane
- Combination of walker and cane



"T" Cane
- Functional grip handle

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-43 AND DEMONSTRATION: VIII-43

TRANSFERRING CLIENTS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Define terms used in this lesson.
2. Describe active assistive transfer and passive transfer.
3. Identify safety measures to observe when transferring clients.
4. Identify four pieces of equipment used for transfer activities.
5. Identify what areas of the body must be checked for proper body alignment.
6. Describe the method of properly positioning a client in the chair.

Demonstration

7. Transfer client from bed to chair according to the steps of procedure.
8. Transfer client from chair to bed according to the steps of procedure.
9. Use mechanical lift to transfer a client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Active Transfer (Assisted)
2. HO 2: Positioning Techniques: Sitting
3. HO 3: Assisting the Hemiplegic Client to Sit with a Cane

4. HO 4: Assisting the Weak Client to Stand with a Walker

5. HO 5: Assisting the Weak Client to Sit with a Walker

6. Transfer Techniques, video #20, available from the Missouri Vocational Resource Center, 21 min.

7. Television and VCR

8. Chair, W/C, or commode

9. Bed

10. Gait belt

11. Mechanical lift, if available

12. Sliding board, if available

13. Arm sling, if available

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 43 (Student Reference page 683) prior to class and be prepared to discuss the information presented and return the procedures on transferring clients.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 28.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 13.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 7, Section 4.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 8.

Restorative Nurse Aide. University of Missouri-Columbia: Instructional Materials Laboratory, 1990.

INTRODUCTION:

Clients in health care facilities should be kept out of bed as much as their physical conditions allow. Getting the client up and into a chair can prevent complications associated with being immobilized. If the client cannot walk, one way to make the client mobile and get him/her out of his/her room is to put the client in a wheelchair. Many of the clients will be dependent upon your help to do this. It is necessary for you to transfer the client in a safe, efficient manner. The principles and procedures apply to clients in acute care and long-term care.

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Contact guarding - client requires hand contact because of occasional loss of balance (protective safeguard)

   B. Independent - client requires no assistance; performs activity safely alone and feels secure

   C. Stand-by assist - client requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly)

   D. Minimal assist - client requires a small amount of help to accomplish activity

   E. Moderate assist - client definitely requires help, but contributes half the effort

   F. Maximal assist - client contributes little or nothing toward execution of activity, is totally dependent

   G. Transfers - methods of moving a client from one surface to another

   H. Unable - client cannot ambulate because of necessary strength or mental capability to perform any part of the activity

II. Methods of Transfer (II-2)

   A. Active assistive - client needs assistance in moving from place to place

      1. Sitting transfers - client remains in sitting position when transferred

      2. Standing transfers - client stands and pivots or takes steps to transfer

         a. Chair to bed; bed to chair

         b. Chair to ambulation device

      3. Lying transfers

         a. Bed to stretcher; stretcher to bed

         b. Using a mechanical lift

B. Passive - client does not assist with transfer

III. Safety Measures **(II-3)**

A. When transferring a client who has a weak side, position the chair on his/her strong side.

B. For a weak client, you need to have control of the shoulders and hips during transfer.

C. Do not attempt to transfer a client who cannot bear any of his/her own body weight by yourself. Determine beforehand how many people will be needed for the transfer.

D. All wheelchairs should have locks that are locked during transfer; a slight movement of the wheelchair could cause a fall.

E. Footrests should be up and out of the way during transfer to prevent the client from tripping or stepping on the rests and falling.

F. Have all equipment handy and checked for safety before beginning procedures.

G. Give the client a thorough explanation of how he/she is to assist. Give client encouragement and praise when he/she assists with the transfer.

H. Client's feet should be flat on the floor approximately 12 inches apart.

I. Practice good body mechanics.

IV. Equipment for Transfer Activities **(II-4)**

A. Sliding Board

1. A smooth, varnished or vinyl board with tapered edges about one foot wide and two feet long

2. One end is tucked in place under the client and the other end is put on the chair or bed.

3. The client's body slides across the board. Dusting the board with talcum powder or cornstarch facilitates sliding.

4. The client may use a trapeze bar to place his/her hands to help him/her lift and move.

5. The board is helpful for a weak or paralyzed client who cannot stand up well enough to transfer to a chair. **(II-5)**

6. The client must be moving to another surface of equal or lower height.

B. Gait belt

1. A special transfer belt that is placed around the client's waist and provides the health care assistant with a handle to hold on to when moving the client

2. It enhances both the safety and comfort of the client during the transfer procedure; prevents injury to client which could be caused by pulling on arms.

3. Useful for ambulating clients--increases safety

4. Apply the belt snugly but not so tight that it causes discomfort or impairs the client's ability to breathe.

C. Mechanical lift

1. A device used to lift and move clients who are unable to do so on their own.

2. Two people are needed to use such a device safely.

3. A lift has the following parts:

    a. A sling in which the client sits

    b. An arm and frame that support the sling

    c. A crank or lever that raises or lowers the arm of the frame

D. Sling

1. A cloth device to cradle an arm or hand that may be injured or paralyzed

2. Supporting the paralyzed extremity in a sling makes it easier for the client to balance in transfer and ambulation activities.

V. Check for Proper Body Alignment **(II-6)**

A. Head should be erect; control of head is necessary to maintain an upright position.

B. Arms supported with pillows.

C. Back should be straight against the back of the chair; place a small pillow at the lower back for comfort and support if client's sitting balance is good.

D. Hips and buttocks should be against the back of the chair.

E. The backs of the knees should be free of pressure from the edge of the chair; there should be room for two or three fingers between the back of the knees and the front of the chair.

F. Feet should be positioned flat on the footrests or the floor; should not be left to dangle.

G. Position still needs to be changed every two hours and the client exercised; if possible, client should stand and walk at two-hour intervals.

H. Have the client shift his/her weight from one side of the buttocks to the other by leaning to the right side and then to the left side every 30 minutes.

VI. Positioning the Client in a Chair **(II-7)**

A. The weight of the client should be supported by the upper legs and buttocks when sitting in a chair or wheelchair.

B. For the client who slides forward in the chair:

1. Apply gait belt.

2. Use two people. They should stand on opposite sides of the client. Each grasps the belt in back and places one hand under the thigh in front. On the count of three, lift and move client back in chair.

VII. Demonstrate Procedures for Transferring Clients. **(II-8 - 11)**

VIII. Summary and Conclusion

A. Methods of transfer

B. Safety measures

C. Equipment for transfer activities

D. Check for proper body alignment

E. Positioning the client in chair

F. Review procedures for transferring clients.

Many of the clients you will be taking care of will need to get out of their beds at least once a day. You must plan ahead and think through the steps before you start. It can be very frightening for some clients who do not get out of bed very often. They may be scared that you will drop them or that they will fall. Take your time and encourage the client to help as much as possible. Your next lesson will be range of motion exercises.

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

STEPS OF PROCEDURE FOR TRANSFERRING CLIENT FROM BED TO CHAIR:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Adjust bed height to low position. Lock brakes of bed.
7. May raise head of bed to bring client to sitting position.
8. Assist client to move over in bed to within five or six inches of the edge of the bed.
9. Assist in putting on socks and nonskid shoes.
10. Position W/C or commode on client's strong side if indicated; if not, brace chair to prevent it from slipping.
11. Place chair parallel to or at a 45° angle to the bed.
12. Lock the wheels of the chair.
13. Cover W/C with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the armrest on the side next to the bed.
14. Position your body facing foot of bed.
15. Put one forearm under client's shoulders and the other behind the knees.
16. Bend your knees, keep your back straight, and stand with feet about 18 inches apart.
17. Straighten your hips and knees while shifting weight from front foot to back foot. At the same time, lift client's head-neck with one arm while pulling the legs over the side of bed with other arm.
18. Apply gait belt.

19. Allow the client time for his/her circulation to adjust to being in a sitting position before you proceed. Assist the client in maintaining a sitting position as needed.

20. Client is able to assist
    a. Place hands underneath belt along the client's side with palms up.

    b. Instruct client to stand on the count of three.

    c. Assist client to stand and support the weak leg with your knee, if indicated.

    d. Instruct client to reach with his/her strong hand and grasp for the far armrest of the chair.

    e. Assist the client to pivot toward his/her strong leg by turning your own body. Do not twist; turn your body as a unit.

    f. Gently assist client to sit by bending your knees while keeping your back straight.

    g. Position the weak arm and leg properly on the armrest and footrest. A pillow may be used to support the weak arm.

    Client is unable to assist
    a. Stand directly in front of the client, grasp the back of the belt.

    b. Support the client's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the client's knees, whatever is comfortable for you and the client.

    c. Have the client lean forward while sitting on the edge of the bed.

    d. On the count of three, have the client push up as much as possible while you pull him/her up by straightening your legs and hips and holding onto the belt.

    e. Pivot your entire body as well as the client's.

    f. Lower the client into the chair by bending at your knees and hips as the client sits down.

    g. Adjust footrest for client; cover with a lap robe.

    h. Position pillow(s) to provide proper body alignment and joint support.

21. Secure a restraint to the chair if ordered by the physician.

22. Make client comfortable and place call signal within reach.

23. Wash your hands.

STEPS OF PROCEDURE FOR TRANSFERRING CLIENT FROM CHAIR TO BED:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Adjust bed height to low position. Lock brakes of bed.
7. Raise head of bed and fanfold bedclothes to end of bed. Make sure opposite side rail is raised.
8. Position chair/wheelchair at side of bed, facing head of bed.
9. Lock wheels and bring up footrests.
10. Place/assist client's feet on floor.
11. Remove lap robe/blanket.
12. Remove safety restraint, if applicable.
13. Apply gait belt.
14. Stand in front of client with feet about 18 inches apart.
15. Place your hands underneath belt. If client is able, have him/her place hands on your shoulders.
16. Assist client to stand.
17. Pivot your body and the client's body toward the bed.
18. Slowly lower client to sitting position on the bed.
19. Remove gait belt.
20. Position your body facing the head of the bed. One foot should be in front of the other foot.
21. Place one forearm on client's shoulders and the other behind the client's knees.
22. Swing/assist client's legs onto the bed as you pivot the client's body.
23. Lower head of bed.

24. Move/assist client to center of bed.

25. Remove slippers.

26. Cover client, position pillows, and straighten bed clothes.

27. Make client comfortable; place call signal within reach.

28. Wash your hands.

STEPS OF PROCEDURE FOR TRANSFERRING CLIENT WITH A MECHANICAL LIFT:

1. Secure the assistance of another health care assistant.

2. Wash your hands.

3. Assemble necessary equipment.

4. Identify and greet client. Identify self and other health care assistant.

5. Explain what you are going to do.

6. Provide privacy.

7. Adjust bed height to low position. Lock brakes of bed.

8. Position chair next to bed with the back of chair in line with the headboard of the bed.

9. By turning the client from side to side on the bed, you can slide the sling under the client.

   NOTE: Make sure the top of the sling is at the crest of the shoulders and the bottom is above the bend of the knees.

10. Wheel the lift into place over the client with the base beneath the bed and be sure to lock the wheels of the lift.

11. Attach the sling to the mechanical lift with the hooks in place under the metal frame.

    NOTE: Be sure to apply hooks with open, sharp ends away from the client.

12. Have the client fold both arms across chest, if possible.

13. Using the crank, lift the client until the buttocks are clear of the bed. Make sure the client is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.

14. One health care assistant should guide the client's legs over the edge of the bed; release brakes on mechanical lift.

15. Move the lift away from the bed, turn the client so that he/she faces you while the other health care assistant guides the client's body toward the chair by standing behind the client.

16. Open the support legs of the lift with the control lever, then bring the lift into position so that the client is over the seat of the chair.

17. Release the control knob slowly so that the client will gradually be lowered into chair.

18. Remove the hooks from the frame of the lift.

19. Cover client with lap robe.

20. Secure the client to the chair with safety restraint if ordered.

21. Make the client comfortable; place call signal within reach.

22. Store lift properly until time to transfer client again.

23. Wash your hands.

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms used in this lesson?
2. What do active assistive and passive transfers mean?
3. What safety measure should be used when transferring a client?
4. What is the description of the four types of equipment used for transfer activities in this lesson?
5. What type of client may use a sliding board? Would the client have to have good muscle strength of the upper extremities?
6. What areas of the client's body must be checked for proper body alignment?
7. How do you position a client in a chair?
8. If the client has a weak side, where should you position the wheelchair?
9. What safety precautions must you take when transferring a client from chair to bed?
10. How do you transfer a client from the chair to the bed?
11. In which direction should the hooks of the mechanical lift that fit into the sling be turned?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show video.
2. Show students equipment used for transfers.
3. Instructor demonstrates how to transfer a client from bed to chair and chair to bed, and the use of the mechanical lift.
4. Students practice transferring each other from bed to chair and chair to bed. Also, use a mechanical lifting device if available.

ANSWERS TO EVALUATION ITEMS:

1.	g
2.	f
3.	e
4.	b
5.	a
6.	h
7.	c
8.	d
9.	b
10.	c
11.	d
12.	a
13.	b
14.	c
15.	b
16.	d
17.	d
18.	d
19.	a
20.	c
21.	d
22.	c

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

Match the terms in Column II to the correct definitions in Column I.

Column I

____ 1. Client definitely requires help, but contributes half the effort

____ 2. Methods of moving a client from one surface to another

____ 3. Client requires no assistance; performs activity safely alone and feels secure

____ 4. Client requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly)

____ 5. Client contributes little or nothing toward execution of activity; is totally dependent

____ 6. Client requires hand contact because of occasional loss of balance (protective safeguard)

____ 7. Client lacks the necessary strength or mental capability to perform any part of the activity or performance is impractical

____ 8. Client requires small amount of help to accomplish activity

Column II

a. Maximal assist

b. Stand-by assist

c. Unable

d. Minimal assist

e. Independent

f. Transfers

g. Moderate assist

h. Contact guarding

9. What is active assistive transfer? (Circle the letter of the best answer.)

a. Client lacks the mental capability to perform the activity.
b. Client needs assistance in moving from place to place.
c. Client does not assist with the transfer.
d. Client is totally dependent.

10. Which of the following is a safety measure for transferring clients? (Circle the letter of the best answer.)

    a. The footrest of the wheelchair should be down when transferring the client.
    b. When transferring a client who has a weak side, always position the chair on his/her weak side.
    c. Do not attempt to transfer a client who cannot bear any of his/her body weight by yourself.
    d. Wheelchairs may be locked during the transfer procedure.

Match the equipment in Column I with the correct description of the equipment in Column II.

Column I	Column II
____ 11. Mechanical lift	a. A special transfer device that is placed around the client's waist
____ 12. Gait belt	b. A cloth device used to cradle the arm or hand
____ 13. Sling	c. A smooth varnished device with tapered edges about one foot wide and two feet long
____ 14. Sliding board	d. A device used to lift and move clients who are unable to do so on their own

15. A sliding board would be used for which one of the following types of clients? (Circle the letter of the best answer.)

    a. Independent client
    b. Weak or paralyzed client who cannot stand up well
    c. One who has a fractured arm or hand
    d. One who can not move on his/her own

16. Which of the following equipment cannot be used for transfers? (Circle the letter of the best answer.)

    a. Gait belt
    b. Mechanical lift
    c. Sliding board
    d. Footboard

17. Which of the following areas of the body should be checked for proper body alignment when the client is positioned in a chair? (Circle the letter of the best answer.)

    a. Head
    b. Hip and buttocks
    c. Feet
    d. All of the above

18. Two health care assistants can position a client in a chair more easily if: (Circle the letter of the best answer.)

    a. One health care assistant instructs the client to let you do all of the work.
    b. One health care assistant completes his/her portion of the move and then the other health care assistant completes his/her portion.
    c. One health care assistant instructs the client to remain limp during the procedure and let you lift him/her.
    d. The two health care assistants move together on the count of "3".

19. When placing a chair to transfer a weak client from the bed to a chair, the chair should be placed: (Circle the letter of the best answer.)

    a. On the client's strong side.
    b. At a 25° angle.
    c. On the client's weak side.
    d. Facing the bed.

20. When you are preparing to transfer a client from the bed into a wheelchair, which one of the following is the most important safety measure? (Circle the letter of the best answer.)

    a. Make certain the four wheels of the chair are aligned.
    b. Ask a co-worker to stand by to help if needed.
    c. Lock the wheels of the chair.
    d. Unlock the wheels of the bed.

21. When transferring a client from the chair to the bed you should: (Circle the letter of the best answer.)

    a. Adjust bed to the high position.
    b. Lower head of bed and fanfold bedclothes.
    c. Position chair at side of bed, facing the foot of the bed.
    d. Pivot your body and the client's body toward the bed.

22. When transferring a client with a mechanical lift, the hooks with the open sharp ends should be turned: (Circle the letter of the best answer.)

    a. Toward the client.
    b. Toward the foot of the bed.
    c. Away from the client.
    d. Toward the crest of the shoulders.

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

TRANSFER CLIENT FROM BED TO CHAIR

EQUIPMENT:

1. Bed
2. Chair
3. Gait belt
4. Safety restraining device if required
5. Lap robe

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Adjust bed height to low position. Lock brakes of bed.		
7. May raise head of bed to bring client to sitting position.		
8. Assist client to move over in bed to within five or six inches of the edge of the bed.		
9. Assist in putting on socks and nonskid shoes.		
10. Position wheelchair or commode on client's strong side if indicated; if not, brace chair to prevent it from slipping.		
11. Place chair parallel to or at a 45° angle to the bed.		
12. Lock the wheels of the chair.		
13. Cover wheelchair with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the armrest on the side next to the bed.		
14. Position your body facing foot of bed.		
15. Put one forearm under client's shoulders and the other behind the knees.		

16.	Bend your knees, keep your back straight, and stand with feet about 18 inches apart.		
17.	Straighten your hips and knees while shifting weight from front foot to back foot. At the same time, lift client's head-neck with one arm while pulling the legs over the side of bed with other arm.		
18.	Apply gait belt.		
19.	Allow the client time for his/her circulation to adjust to being in a sitting position before you proceed. Assist the client in maintaining a sitting position as needed.		
20.	Client is able to assist a. Place hands underneath belt along the client's side with palms up.		
	b. Instruct client to stand on the count of three.		
	c. Assist client to stand and support the weak leg with your knee, if indicated.		
	d. Instruct client to reach with his/her strong hand and grasp for the far armrest of the chair.		
	e. Assist the client to pivot toward his/her strong leg by turning your own body. Do not twist; turn your body as a unit.		
	f. Gently assist client to sit by bending your knees while keeping back straight.		
	g. Position the weak arm and leg properly on the armrest and footrest. A pillow may be used to support the weak arm.		
	Client is unable to assist a. Stand directly in front of the client, grasp the back of the belt.		
	b. Support the client's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the client's knees, whatever is comfortable for you and the client.		
	c. Have the client lean forward while sitting on the edge of the bed.		
	d. On the count of three, have the client push up as much as possible while you pull him/her up by straightening your legs and hips and holding onto the belt.		
	e. Pivot your entire body as well as the client's.		

	f. Lower the client into the chair by bending at your knees and hips as the client sits down.		
	g. Adjust footrest for client; cover with a lap robe.		
	h. Position pillow(s) to provide proper body alignment and joint support.		
21.	Secure a restraint to the chair if ordered by the doctor.		
22.	Make client comfortable and place call signal within reach.		
23.	Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT FROM BED TO CHAIR" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

TRANSFER CLIENT FROM CHAIR TO BED

EQUIPMENT:

1. Bed
2. Chair
3. Gait belt

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Adjust bed height to low position. Lock brakes of bed.		
7. Raise head of bed and fanfold bedclothes to end of bed. Make sure opposite side rail is raised.		
8. Position chair/wheelchair at side of bed, facing head of bed.		
9. Lock wheels and bring up footrests.		
10. Place/assist client's feet on floor.		
11. Remove lap robe/blanket.		
12. Remove safety restraint, if applicable.		
13. Apply gait belt.		
14. Stand in front of client with feet about 18 inches apart.		
15. Place your hands underneath belt. If client is able, have him/her place hands on your shoulders.		
16. Assist client to stand.		
17. Pivot your body and the client's body toward the bed.		
18. Slowly lower client to sitting position on the bed.		

19.	Remove gait belt.		
20.	Position your body facing the head of the bed. One foot should be in front of the other foot.		
21.	Place one forearm on client's shoulders and the other behind the client's knees.		
22.	Swing/assist client's legs onto the bed as you pivot the client's body.		
23.	Lower head of bed.		
24.	Move/assist client to center of bed.		
25.	Remove slippers.		
26.	Cover client, position pillows, and straighten bed clothes.		
27.	Make client comfortable; place call signal within reach.		
28.	Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT FROM CHAIR TO BED" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 43

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

TRANSFER CLIENT WITH A MECHANICAL LIFT

EQUIPMENT:

1. Bed
2. Chair
3. Mechanical Lift

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Secure the assistance of another health care assistant.		
2. Wash your hands.		
3. Assemble necessary equipment.		
4. Identify and greet client. Identify self and other health care assistant.		
5. Explain what you are going to do.		
6. Provide privacy.		
7. Adjust bed height to low position. Lock brakes of bed.		
8. Position chair next to bed with the back of chair in line with the headboard of the bed.		
9. By turning the client from side to side on the bed, you can slide the sling under the client. NOTE: Make sure the top of the sling is at the crest of the shoulders and the bottom is above the bend of the knees.		
10. Wheel the lift into place over the client with the base beneath the bed and be sure to lock the wheels of the lift.		
11. Attach the sling to the mechanical lift with the hooks in place under the metal frame. NOTE: Be sure to apply hooks with open, sharp ends away from the client.		
12. Have the client fold both arms across chest, if possible.		

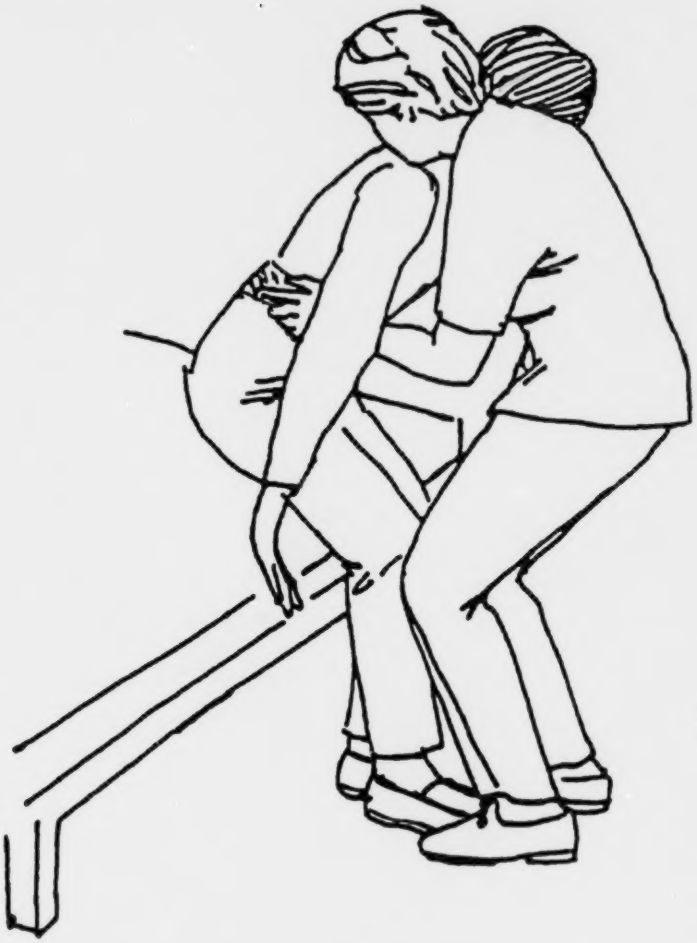
13.	Using the crank, lift the client until the buttocks are clear of the bed. Make sure the client is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.		
14.	One health care assistant should guide the client's legs over the edge of the bed; release brakes on mechanical lift.		
15.	Move the lift away from the bed, turn the client so that he/she faces you while the other health care assistant guides the client's body toward the chair by standing behind the client.		
16.	Open the support legs of the lift with the control lever, then bring the lift into position so that the client is over the seat of the chair.		
17.	Release the control knob slowly so that the client will gradually be lowered into chair.		
18.	Remove the hooks from the frame of the lift.		
19.	Cover client with lap robe.		
20.	Secure the client to the chair with safety restraint if ordered.		
21.	Make the client comfortable; place call signal within reach.		
22.	Store lift properly until time to transfer client again.		
23.	Wash your hands.		

The student has satisfactorily completed the procedure "TRANSFER CLIENT WITH A MECHANICAL LIFT" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature (Verifying Satisfactory Completion)

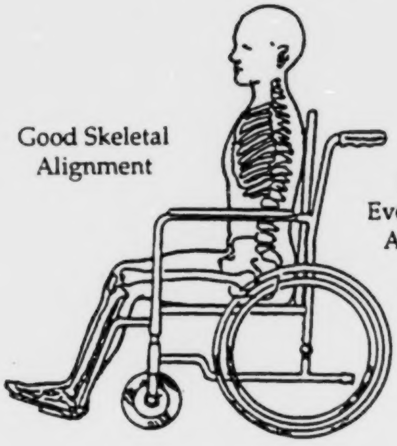
Date

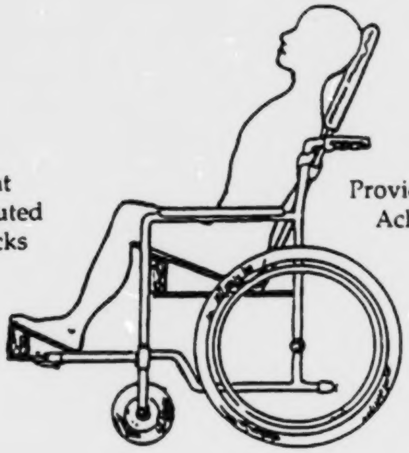
ACTIVE TRANSFER (ASSISTED)



HO 2

POSITIONING TECHNIQUES: SITTING

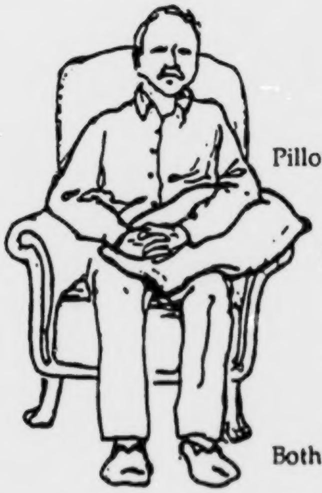

Good Skeletal Alignment
Body Weight Evenly Distributed Across Buttocks


Provide External Supports to Achieve Proper Position

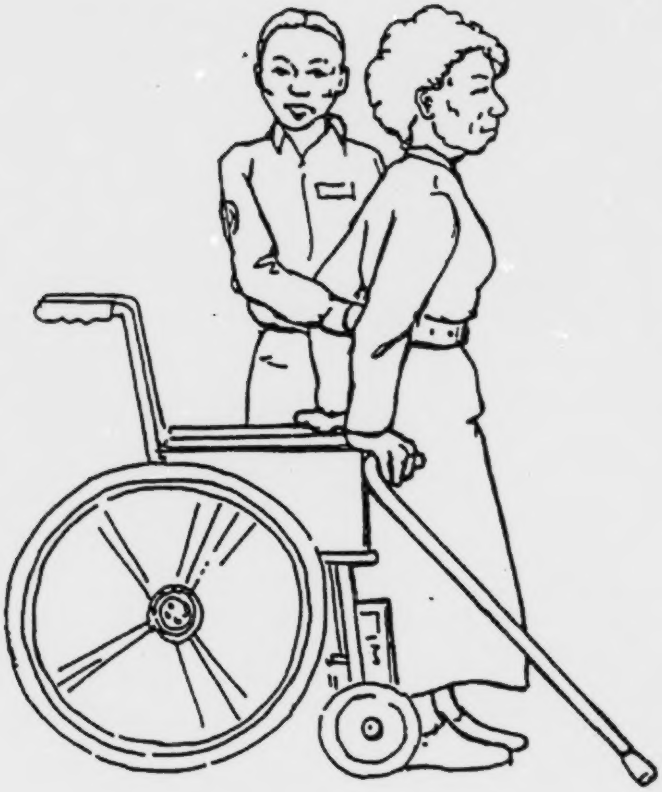
Points to Remember

- Position away from spastic patterns.
- Encourage symmetrical postures.
- Do not force uncomfortable positions.
- Be sensitive to client's appearance.

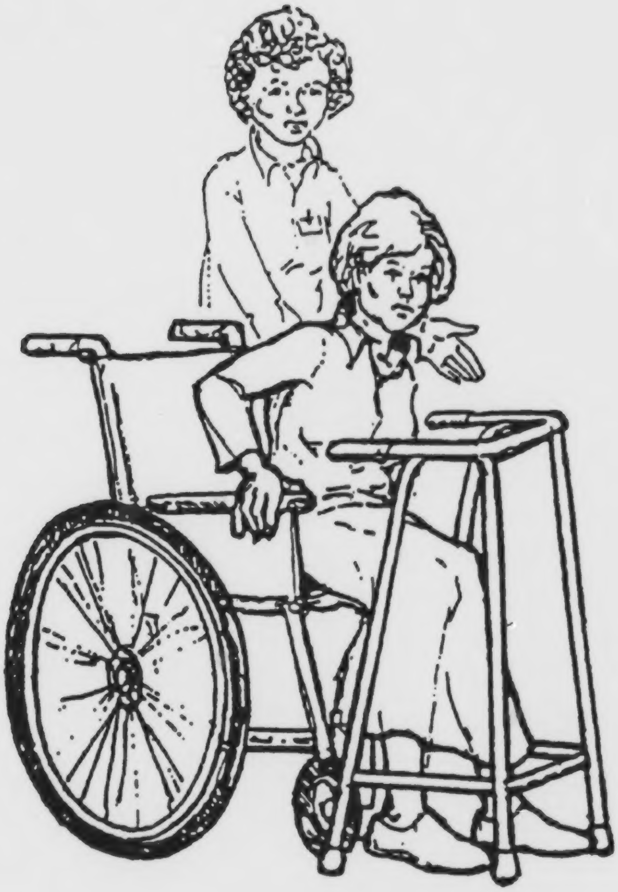
Adaptations for the Ambulatory Resident


Pillow Supporting Left Arm
Fingers Interlaced
Both Feet Positioned at 90°

ASSISTING THE HEMIPLEGIC CLIENT TO SIT WITH A CANE

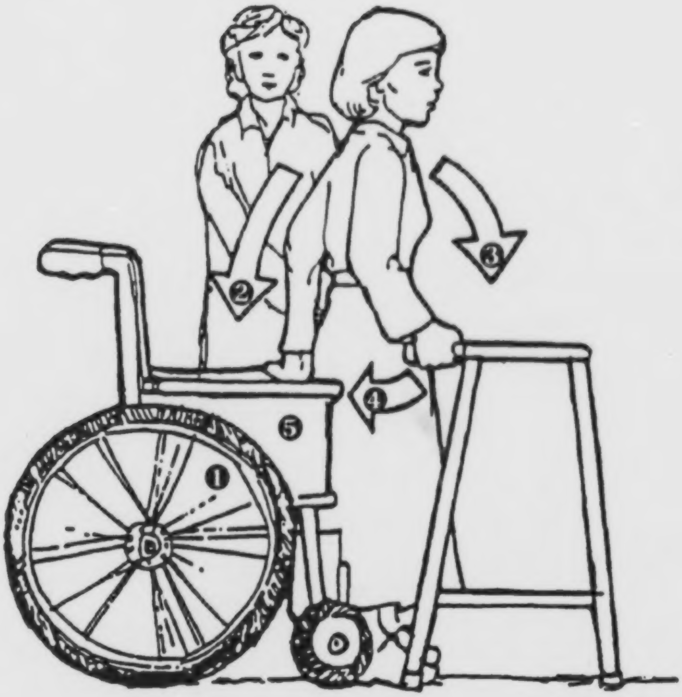


ASSISTING THE WEAK CLIENT TO STAND WITH A WALKER



1. Lock wheelchair brakes.
2. Hands on armrests.
3. Flex trunk forward.
4. Push with arms and legs to stand.
5. Steady - place hands on walker.

ASSISTING THE WEAK CLIENT TO SIT WITH A WALKER



1. Lock wheelchair brakes.
2. Reach back with one arm to armrest.
3. Flex trunk-weight over feet.
4. Reach back with other hand to armrest.
5. Sit - reposition in wheelchair for comfort.

LESSON PLAN: 44

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

SCOPE OF UNIT:

This unit contains terminology, structure, description, function, and diagrams of the musculoskeletal system. The unit includes using body mechanics to lift and move clients, bed making, ambulation, transfer activities, and range of motion exercises.

INFORMATION TOPIC: VIII-44 AND DEMONSTRATION: VIII-44

RANGE OF MOTION EXERCISES

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. List the purposes of range of motion exercises.
3. List the health care assistant's responsibilities when giving range of motion exercises.

Demonstration

4. Give range of motion exercises according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Range of Motion Exercises

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 44 (Student Reference page 707) prior to class and be prepared to discuss the information presented and return the demonstrations on giving range of motion exercises.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Units 17 and 24.

Schniedman, Rose; Susan Lambert; Barbara, Wander. Being a Nurse Assistant. 5th ed. The Hospital Research and Educational Trust, 1989. Chapter 48.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 8.

INTRODUCTION:

Range of motion exercises are given to move the joints of the body through their normal movements. These exercises are given to prevent stiffness and deformities and to maintain muscle strength. When doing these exercises, work slowly and smoothly; don't exercise a joint past the point of pain/resistance. Always support an extremity at the joint by cupping with your hand. Never grasp the muscle as this can be painful. Encourage the client to do as much as possible. Do the exercises as many times as instructed by the charge nurse. In addition to the physical advantages, clients often express appreciation for the relaxing effects that result from range of motion exercises. The following procedure covers a logical sequence so that each joint and muscle is exercised.

830

LESSON PLAN: 44

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Abduction - away from the center of the body

   B. Active range of motion exercises - movements carried out by the client

   C. Adduction - toward the center of the body

   D. Eversion - a turning outward

   E. Extension - to straighten

   F. Flexion - to bend

   G. Hyperextension - extensive extension

   H. Inversion - a turning inward

   I. Lateral - to the side

   J. Passive range of motion exercises - movements carried out by the staff routinely to prevent complications

   K. Pronation - to bend downward

   L. Rotation - to move a joint in a circular motion

   M. Supination - to be bent upward

II. Purposes (II-2)

   A. Musculoskeletal system must be exercised to remain healthy.

   B. Exercises prevent joints from becoming stiff and contractures (deformities) from developing.

   C. They prevent muscles from losing strength and shrinking (atrophy).

   D. ROM exercises prevent loss of minerals from bones.

   E. They prevent slowing of circulation.

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III. Health care assistant's Responsibilities

  A. Always check with charge nurse for instructions or limitations before starting range of motion exercise.

  B. Exercises are usually done during or after the bath but may be done at other times.

  C. Never exercise a joint to the point of pain.

  D. Exercise as many times as ordered - usually 3 to 5 times.

  E. Always stop the exercise if discomfort or pain develops and report to the charge nurse. **(II-3)**

  F. Support each joint above and below the joint being exercised. This prevents pressure on the muscles. **(II-4)**

  G. Always handle the client gently.

  H. Remember hyperextension is not possible with the client in a supine position.

  I. Allow client to assist in procedure as much as possible.

IV. Demonstrate Procedures for Giving Range of Motion Exercises.

V. Summary and Conclusion

  A. Terms and definitions

  B. Purposes

  C. Health care assistant's responsibilities

  D. Review procedures for giving range of motion exercises.

This lesson has been over the importance of range of motion exercises and the correct procedure for giving range of motion exercises. The next unit will be the cardiovascular system and procedures related to that system.

LESSON PLAN: 44

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

STEPS OF PROCEDURE FOR GIVING RANGE OF MOTION EXERCISES:

1. Wash your hands.
2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Provide privacy--make sure client is wearing adequate clothing.
5. Raise bed to a comfortable working height.
6. Assist client into supine position.
7. Neck
    a. Flexion/extension
        (1) Support head with hands and bend head forward trying to touch the chest with the chin.
        (2) Bring head back to pillow.

        NOTE: Hyperextension is not possible with client in supine position.
    b. Right and left rotation - turn head from side to side
8. Shoulders
    a. Flexion/extension
        (1) Support the arm at the wrist and elbow and lift the arm toward the ceiling. Continue lifting the arm over the client's head until you feel resistance.
        (2) Slowly lower the arm to the client's side.
    b. Abduction/adduction
        (1) Support the arm at the elbow and shoulder and move the arm out to the side, continue moving toward client's head.
        (2) Slowly move the arm back toward the center of body.

c. Inversion/eversion

(1) Move the arm away from the body to shoulder level.

(2) Bring the hand forward to touch the bed and then backward to touch the bed.

9. Elbow

a. Flexion/extension

(1) Bend the arm at the elbow and touch the shoulder, then straighten the arm.

(2) Bend the arm at the elbow and touch the chin, then straighten the arm.

b. Pronation/supination

(1) Hold the client's hand in a handshake position; support the arm at the elbow joint.

(2) Turn palm of the hand toward floor and then away from the floor.

10. Wrist

a. Flexion/extension/hyperextension - support arm and hand; bend the wrist forward, straighten it, and then bend it backward.

b. Abduction/adduction - move the hand from side to side at the wrist.

11. Fingers

a. Flexion/extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct client to make a clenched fist and then relax it.

b. Abduction/adduction - move each finger away from the nearest finger and then return it.

c. Thumb opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back.

d. Thumb rotation - move the thumb in a circle one direction and then the other direction.

12. Hip and knee

a. Flexion/extension

    (1) Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.

    (2) Bend the knee and move toward the chest, slowly straighten the knee.

  b. Abduction/adduction

    (1) Move the leg straight out to the side of the body until you feel resistance.

    (2) Slowly move the leg back toward the center of the body.

  c. Inversion/eversion - support the knee and ankle joints; move the ankle in toward the opposite leg and then outward.

13. Ankle

  a. Inversion/eversion - support the foot at the ankle joint and turn the foot toward the opposite foot and then away from the opposite foot.

  b. Dorsiflexion/plantarflexion - bend the foot up toward the knee, then down toward the floor.

14. Toes

  a. Flexion/extension - bend and then straighten the toes.

  b. Abduction/adduction - move each toe toward the next toe and then away from the next toe.

15. Lower bed to a position of safety; raise side rails where ordered.

16. Make the client comfortable; place call signal within reach.

17. Wash your hands.

LESSON PLAN: 44

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

INTERACTION ITEMS:

1. **What is the definition of terms presented in this lesson?**
2. **What are the five purposes of range of motion exercises?**
3. **If a client complains of unusual pain/discomfort, what should you do?**
4. **Where are joints supported when giving range of motion exercise?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Instructor demonstrates range of motion exercises.**
2. **Students practice range of motion exercises on each other.**
3. **Discuss handouts.**

ANSWERS TO EVALUATION ITEMS:

1. j
2. g
3. f
4. c
5. b
6. e
7. a
8. h
9. k
10. i
11. d

12. The student can list any three of the following:
    a. Musculoskeletal system must be exercised to remain healthy.
    b. Exercises prevent joints from becoming stiff and contractures (deformities) from developing.
    c. They prevent muscles from losing strength and shrinking (atrophy).
    d. ROM exercises prevent loss of minerals from bones.
    e. They prevent slowing of circulation.
13. c
14. c

LESSON PLAN: 44

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII : THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS:

Match the following terms in Column I to the correct definitions in Column II by writing the letter in the blank.

	Column I		Column II
___ 1.	Supination	a.	To turn out away from center
___ 2.	Inversion	b.	A turning outward
___ 3.	Lateral	c.	Extensive straightening
___ 4.	Hyperextension	d.	To bend
___ 5.	Abduction	e.	To straighten
___ 6.	Extension	f.	To the side
___ 7.	Eversion	g.	A turning inward
___ 8.	Pronation	h.	To bend downward
___ 9.	Rotation	i.	Toward the center of the body
___10.	Adduction	j.	To bend upward
___11.	Flexion	k.	To move a joint in a circular motion

12. List three purposes of range of motion exercises.

    a.

    b.

    c.

13. When giving range of motion exercises, the health care assistant should support the joint: (Circle the letter of the best answer.)

a. At the joint with a firm grip.
b. It is not necessary to support the joint.
c. Above and below the joint.
d. Above the joint only.

14. When assigned to perform range of motion exercises, the health care assistant's responsibility is to: (Circle the letter of the best answer.)

a. Give range of motion exercises only during the bath.
b. Exercise joints to the point of pain.
c. Always stop the exercise if pain or discomfort develops.
d. Not support joints because it will limit the exercise.

LESSON PLAN: 44

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT VIII: THE MUSCULOSKELETAL SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

GIVE RANGE OF MOTION EXERCISES

EQUIPMENT:

1. Hospital bed made up with linens

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Identify and greet client. Identify self.		
3. Explain what you are going to do.		
4. Provide privacy--make sure client is wearing adequate clothing.		
5. Raise bed to a comfortable working height.		
6. Assist client into supine position.		
7. Neck a. Flexion/extension (1) Support head with hands and bend head forward trying to touch the chest with the chin.		
(2) Bring head back to pillow. NOTE: Hyperextension is not possible with client in supine position.		
b. Right and left rotation - turn head from side to side.		
8. Shoulders a. Flexion/extension (1) Support the arm at the wrist and elbow and lift the arm toward the ceiling. Continue lifting the arm over the client's head until you feel resistance.		
(2) Slowly lower the arm to the client's side.		
b. Abduction/adduction (1) Support the arm at the elbow and shoulder and move the arm out to the side, continue moving toward client's head.		
(2) Slowly move the arm back toward the center of body.		

c. Inversion/eversion (1) Move the arm away from the body to shoulder level.		
(2) Bring the hand forward to touch the bed and then backward to touch the bed.		
9. Elbow a. Flexion/extension (1) Bend the arm at the elbow and touch the shoulder, then straighten the arm.		
(2) Bend the arm at the elbow and touch the chin, then straighten the arm.		
b. Pronation/supination (1) Hold the client's hand in a handshake position; support the arm at the elbow joint.		
(2) Turn palm of the hand toward floor and then away from the floor.		
10. Wrist a. Flexion/extension/hyperextension - support arm and hand; bend the wrist forward, straighten it, and then bend it backward.		
b. Abduction/adduction - move the hand from side to side at the wrist.		
11. Fingers a. Flexion/extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct client to make a clenched fist and then relax it.		
b. Abduction/adduction - move each finger away from the nearest finger and then return it.		
c. Thumb opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back.		
d. Thumb rotation - move the thumb in a circle one direction and then the other direction.		
12. Hip and knee a. Flexion/extension (1) Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.		
(2) Bend the knee and move toward the chest, slowly straighten the knee.		
b. Abduction/adduction (1) Move the leg straight out to the side of the body until you feel resistance.		

(2) Slowly move the leg back toward the center of the body.		
c. Inversion/eversion - support the knee and ankle joints; move the ankle in toward the opposite leg and then outward.		
13. Ankle a. Inversion/eversion - support the foot at the ankle joint and turn the foot toward the opposite foot and then away from the opposite foot.		
b. Dorsiflexion/plantarflexion - bend the foot up toward the knee, then down toward the floor.		
14. Toes a. Flexion/extension - bend and then straighten the toes.		
b. Abduction/adduction - move each toe toward the next toe and then away from the next toe.		
15. Lower bed to a position of safety; raise side rails where ordered.		
16. Make the client comfortable; place call signal within reach.		
17. Wash your hands.		

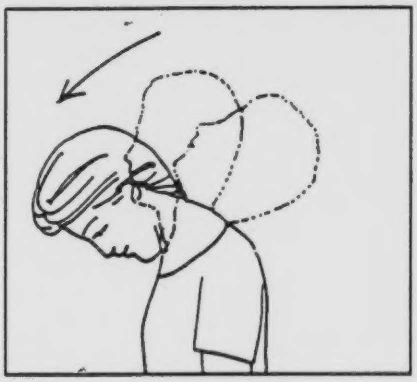
The student has satisfactorily completed the procedure "GIVE RANGE OF MOTION EXERCISES" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

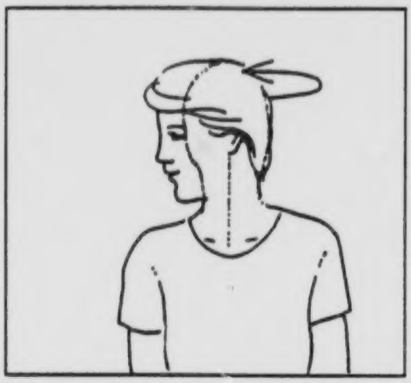
Date

RANGE OF MOTION EXERCISES

NECK

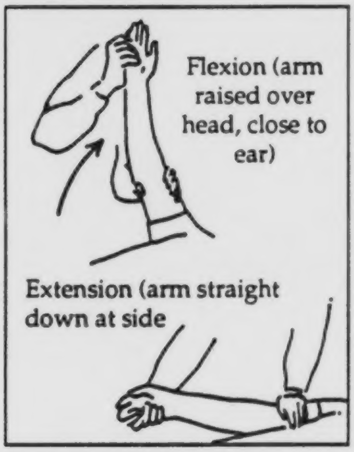


1. Flexion/Extension



2. Right and Left Rotation

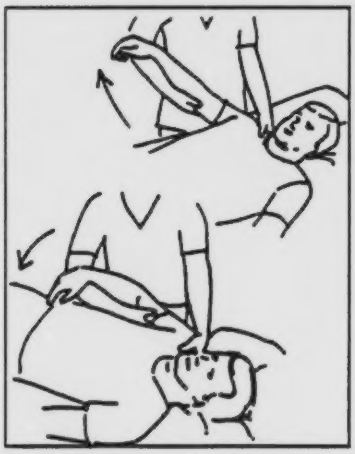
SHOULDERS



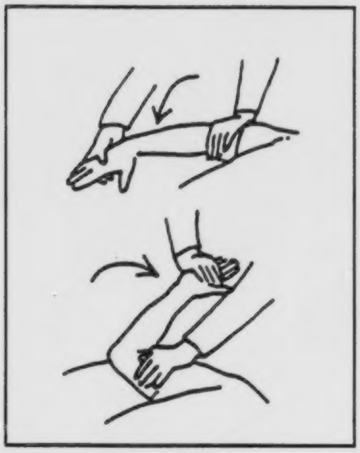
Flexion (arm raised over head, close to ear)

Extension (arm straight down at side

1. Flexion/Extension

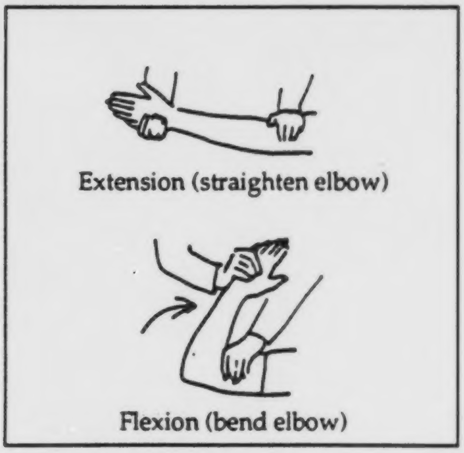


2. Abduction/Adduction



3. Inversion/Eversion

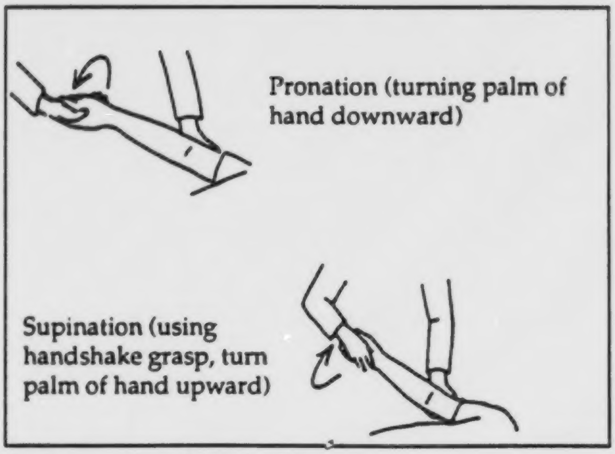
ELBOW



Extension (straighten elbow)

Flexion (bend elbow)

1. Flexion/Extension

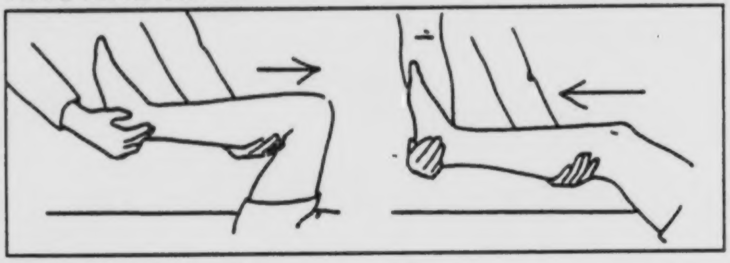


Pronation (turning palm of hand downward)

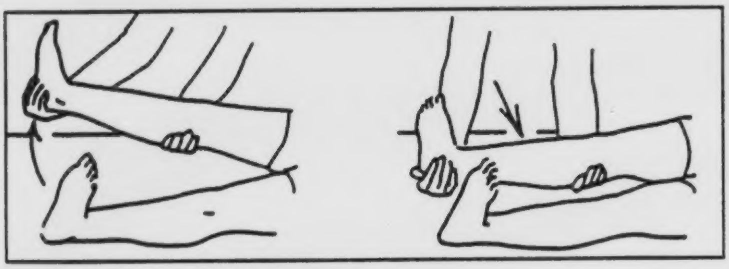
Supination (using handshake grasp, turn palm of hand upward)

2. Pronation/Supination

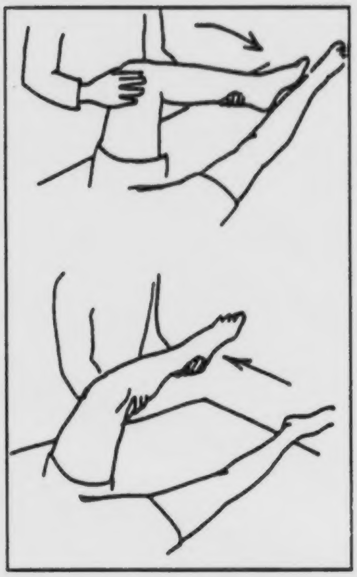
HIPS AND KNEE



1. Flexion/Extension

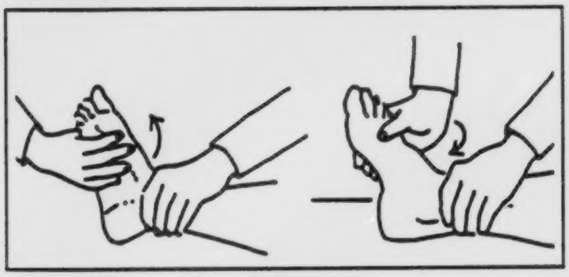


2. Abduction/Adduction

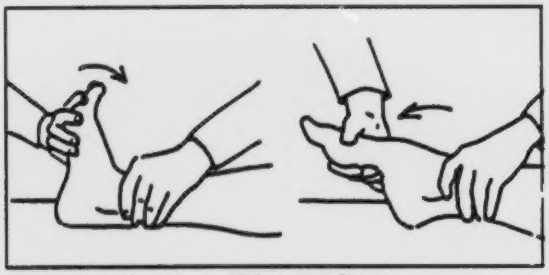


3. Inversion/Eversion

ANKLE

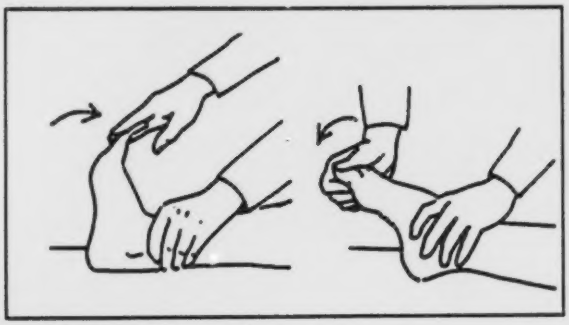


1. Inversion/Eversion

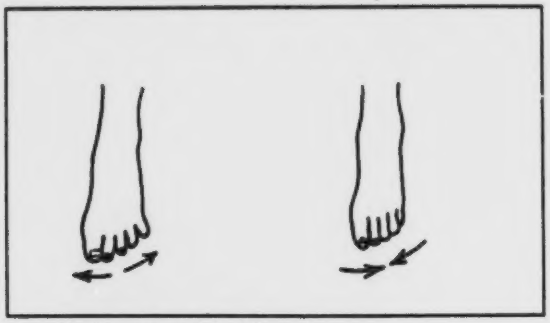


2. Dorsiflextion/Plantarflexion

TOES

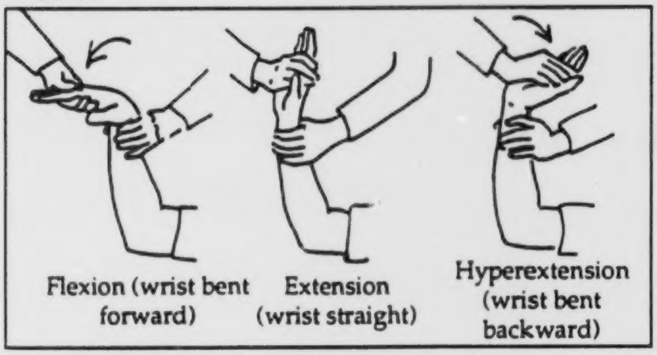


1. Flexion/Extension

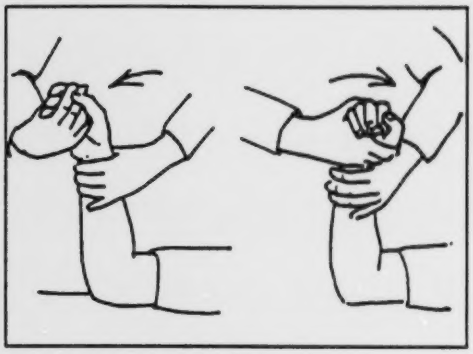


2. Abduction/Adduction

WRIST

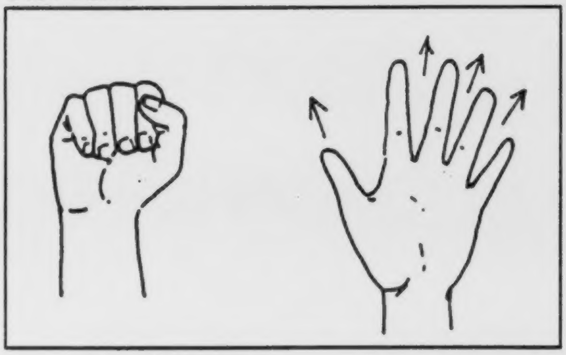

Flexion (wrist bent forward)
Extension (wrist straight)
Hyperextension (wrist bent backward)

1. Flexion/Extension/Hyperextension

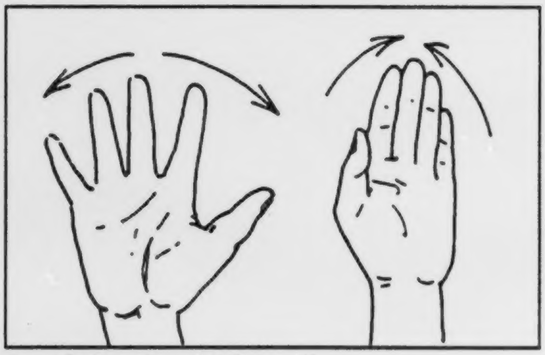


2. Abduction/Adduction

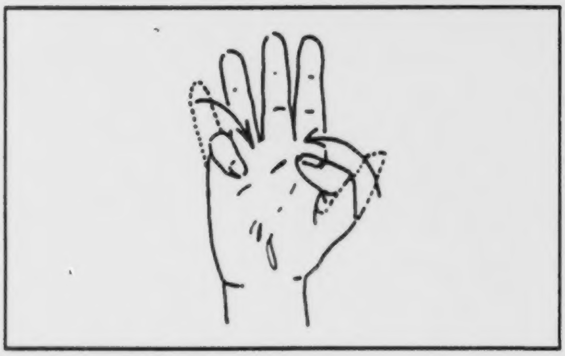
FINGERS



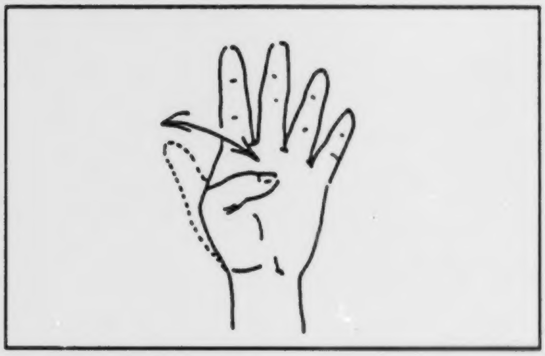
1. Flexion/Extension



2. Abduction/Adduction



3. Thumb Opposition



4. Thumb Rotation

LESSON PLAN: 45

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

SCOPE OF UNIT:

This unit examines the structure and function of the cardiovascular system, including the heart and circulation, the lymphatics, blood vessels, and blood. Medical terms and definitions relating to the cardiovascular system are included. Vital signs are also included in this unit.

INFORMATION TOPIC: IX-45 OR DEMONSTRATION:

HEART AND CIRCULATION
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with the correct definitions.
2. Describe the location of the heart.
3. Describe the function of the heart.
4. Describe the structure of the heart.
5. List the function of the heart conduction system and locate the component parts.
6. Trace the path of circulation.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Cardiovascular System
2. HO 2: Conduction System of the Heart
3. HO 3: Path of Circulation
4. Wall chart of the heart
5. Anatomical models
6. American Heart Association film: "New Heart and Circulatory System"

7. American Heart Association film: "I am Your Heart"

8. State Fair Community College Media Center:

   a. The Heart, Slide/tape HO-R83-550
   b. Circulation, Slide/tape HO-R83-553

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 45 (Student Reference page 721) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

The circulatory system is made up of the blood, heart, and blood vessels (arteries, veins, capillaries). Your heart weighs approximately 12 to 13 ounces and is about 5 inches long and 3 1/2 inches wide. The heart is the pump of the body. It is a very complex structure that involves the nervous system and muscular system, as well as the circulatory system.

The heart is vital to life. If your heart stops beating, life stops. You will lose consciousness if the blood flow to your brain ceases for 5 seconds. The muscles twitch convulsively after 15 to 20 seconds. Brain cells are dead after 9 minutes without blood flow.

LESSON PLAN: 45

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX : THE CARDIOVASCULAR SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

A. Aortic-semilunar valve - consists of three half-moon shaped cups; located between junction of aorta and left ventricle of heart

B. Aorta - largest artery in body, rising from left ventricle of the heart; carries oxygenated blood to all parts of the body

C. Apex - pointed end of a conical structure

D. Artery - a blood vessel that carries blood away from the heart

E. Cardiac - pertaining to the heart

F. Aneurysm - blood-filled, saclike dilation of the wall of an artery

G. Angina - any disease characterized by spasmodic suffocative attacks

H. Arteriosclerosis - hardening of the arteries

I. Atrial fibrillation - rapid, irregular rhythm, and intensity of the heart beat; irregular atrial impulses and ineffective atrial contractions

J. Atrioventricular valves - tricuspid and mitral (bicuspid) valves of the heart

K. Atrium - heart's upper chambers

L. Brachycephalic artery - located on the right side of aortic arch; divided into the right subclavian and right common carotid arteries

M. Cardiac arrest - heart fails to pump blood

N. Cardiac arrhythmia - change in the normal rhythm and beat of the heart

O. Cardiac muscle - the muscle of the heart

P. Cardiopulmonary resuscitation - the procedure for maintaining respiration and heart beat by manual means when breathing and heart beats have stopped

Q. Carotid artery - supplies blood to the neck and head

R. Coronary - refers to the blood vessels of the heart

S. Endocardium - membrane which lines interior of heart

T. Pericardium - membrane sac that surrounds the heart

U. Myocardium - heart muscle

V. Sinoatrial node - conduction system located at the junction of the superior vena cava and right atrium (Purkinje fibers)

W. Vein - a vessel which carries blood to the heart

X. Ventricle - the two lower chambers of the heart

Y. Systole - active phase of heart contraction

Z. Diastole - relaxation phase of heart contraction

AA. Cardiologist - a specialist in treating disorders of the heart

AB. Cardiology - the science and study of the heart

II. Location of the Heart (II-2)

A. In the thoracic cavity

B. Behind the sternum, in front of the thoracic vertebrae, and above the diaphragm

C. If you draw a line down the middle of the chest, you will note that two thirds of the heart is to the left of this line and one third is to the right of the line

D. Apex - points toward the left and lies on the diaphragm

III. Function of the Heart (HO 1)

A. Acts as a pump for the blood, which carries nutrients, oxygen, and other elements needed by the cells (II-3)

IV. Structure of the Heart

A. Covering (II-4)

1. Pericardium - outer double layer which covers the heart

a. Parietal layer

b. Visceral layer

2. Function

   a. Anchorage of the heart

   b. Prevents friction when the heart beats; between the two layers is a lubricating fluid called pericardial fluid

B. Layers

   1. Serous pericardium - thin inner layer covering the heart

   2. Fibrous pericardium - tough outer membrane

   3. Myocardium or cardiac muscle - makes up the wall of the heart

   4. Endocardium - a smooth tissue that covers the heart valves and lines the blood vessels

C. Septum - thick muscular wall separating the heart into a right half and left half **(II-5)**

D. Four chambers

   1. Upper chambers

      a. Right atrium (auricle)

      b. Left atrium (auricle)

   2. Lower chambers

      a. Right ventricle

      b. Left ventricle

E. Valves - prevent blood from flowing backward into the chambers of the heart **(II-6)**

   1. Atrioventricular valves

      a. Tricuspid

         (1) Located between right atrium and right ventricle

         (2) Allows blood to flow from right atrium into right ventricle; prevents blood from flowing back into the right atrium

      b. Mitral bicuspid valve

         (1) Located between the left atrium and left ventricle

(2) Allows blood flow from the left atrium to the left ventricle; prevents blood from flowing back into the atrium

2. Semilunar valves

a. Pulmonary semilunar valve

(1) Located at the opening of the pulmonary artery

(2) Allows blood to flow from the right ventricle into the pulmonary artery and then to the lungs

b. Aortic semilunar valve

(1) Located at the opening of the aorta

(2) Allows blood to pass from the left ventricle into the aorta; prevents blood from passing back into the ventricle

V. Conduction System of the Heart (Heart Contractions) (II-7)

A. Description (HO 2)

1. Located in the wall of the heart are four structures: sinoatrial node (SA node or pacemaker) atrioventricular node (AV node), the bundle of His (atrioventricular bundle), and the Purkinje fibers.

B. Normal path of conduction

1. Conduction normally starts in the SA node.

2. The SA node stimulates the contraction of both atria. At this time, blood flows into the ventricles from the atria. It passes through the tricuspid and mitral valves. At the same time, the ventricles are filling with blood.

3. The AV node stimulates the contraction of both ventricles. Blood in the ventricles is pumped into the pulmonary artery and the aorta through the semilunar valves.

4. The ventricles relax and the semilunar valves are closed. This prevents the flow of blood back into the ventricles. The cycle repeats itself.

VI. Path of Circulation (HO 3) **(II-8)**

A. Deoxygenated blood from the head, neck, and arms returns to the right side of the heart by the superior vena cava. The superior vena cava is one of the two largest veins in the body.

B. Deoxygenated blood from the legs and trunk enters the heart by the large inferior vena cava veins

C. Blood from both the superior vena cava and inferior vena cava, enters the right atrium.

D. Right atrium contracts and forces the blood through the tricuspid valve into the right ventricle.

E. The right ventricle contracts and pushes the blood through the pulmonary semilunar valve.

F. The right and left pulmonary arteries bring the deoxygenated blood to the right and left lungs.

G. Inside the lungs

1. Pulmonary arteries branch into arterioles (many small arteries).

2. Arterioles are connected to capillaries within the alveoli lung tissue. It is here that carbon dioxide leaves the red blood cells and is eventually exhaled from the body.

3. In the alveoli, oxygen combines with hemoglobin in the red blood cells.

4. Oxygenated blood then travels to the small venule veins.

5. Venules from the right lung form the two large pulmonary veins.

6. The right pulmonary veins carry oxygenated blood from the right lung back to the heart and into the left atrium.

7. From the left lung, two pulmonary veins take the blood to the left atrium.

H. The left atrium contracts and the blood passes through the bicuspid valve into the left ventricle.

I. Left ventricle contracts and sends oxygenated blood through the aortic semilunar valve into the aorta.

J. Aorta - the largest artery in the body

1. The aorta as it emerges from the anterior of the heart forms an arch which is called the aortic arch

2. Aortic arch has three branches: the brachycephalic, the left common carotid, and left subclavian arteries. These arteries carry blood to the arms, neck, and head.

3. The descending aorta forms from the aortic arch which carries oxygenated blood throughout the body.

4. The coronary artery is the first branch from the aorta and is the artery that carries blood to the heart muscle.

5. The descending aorta carries blood to the lower part of the body.

K. Arteries branch into arterioles.

L. Arterioles branch into the capillaries where oxygen and glucose pass into the cells. Carbon dioxide and waste materials pass into the capillaries.

M. Capillaries carry the deoxygenated blood to the venules which connect to the veins.

N. The veins ultimately connect with the superior vena cava or inferior vena cava.

VII. Summary and Conclusion

A. Terms and definitions

B. The heart

C. Conduction system

D. Path of circulation

This lesson has been over the structure, function, and conduction system of the heart and circulation of blood. Your next lesson will be over blood cells, blood types, and lymphatic system.

LESSON PLAN: 45

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms found in this lesson?
2. Where is the heart located?
3. What is the function of the heart?
4. What is the outer double layer covering of the heart called?
5. What are the four chambers of the heart?
6. Where are the tricuspid, mitral, semilunar, and aortic valves located?
7. Where are the component parts of the heart's conduction system located?
8. What is the path of circulation of blood through the body?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Dissect and examine a heart (beef, etc.). Discuss structure, conduction, and circulation.
2. Invite EKG technician to class - show EKG or if possible run a strip in class.

ANSWERS TO EVALUATION ITEMS:

1. b
2. e
3. f
4. a
5. c
6. d
7. blood
8. c
9. d
10. c
11. b

12. b AV node
    d Purkinje's fibers

a SA node
c Bundle of His

13. a. Superior vena cava
b. Pulmonary semilunar valve
c. Right atrium
d. Tricuspid valve
e. Right ventricle
f. Inferior vena cava
g. Septum
h. Endocardium
i. Left ventricle
j. Aortic semilunar valve
k. Mitral valve
l. Coronary arteries
m. Left atrium
n. Pulmonary veins
o. Pulmonary artery
p. Aorta

LESSON PLAN: 45

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX : THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

		Column I		Column II
____	1.	Vein	a.	Refers to the blood vessels of the heart
____	2.	Aorta	b.	A vessel that carries blood to the heart
____	3.	Artery	c.	Pertaining to the heart
____	4.	Coronary	d.	Heart's upper chamber
____	5.	Cardia	e.	Largest artery in the body
			f.	A blood vessel that carries blood away from the heart

6. Where is the heart located? (Circle the letter of the best answer.)

   a. At the lower end of the trachea, in front of the cervical vertebrae, and below the diaphragm
   b. Upper part of the abdominal cavity just to the left and below the diaphragm
   c. On the right side of the abdominal cavity, slightly underneath the diaphragm
   d. Behind the sternum, in front of the thoracic vertebrae, and above the diaphragm

7. The heart acts as a pump for the ____.

8. What is the outer double layer covering of the heart called? (Circle the letter of the best answer.)

   a. Myocardium
   b. Endocardium
   c. Pericardium
   d. Atrium

9. The upper chambers of the heart are called the right and left: (Circle the letter of the best answer.)

   a. Myocardium.
   b. Endocardium.
   c. Ventricles.
   d. Atrium.

10. The lower chambers of the heart are called the right and left: (Circle the letter of the best answer.)

   a. Myocardium.
   b. Endocardium.
   c. Ventricles.
   d. Atrium.

11. Where is the tricuspid valve located? (Circle the letter of the best answer.)

   a. At the opening of the aorta
   b. Between the right atrium and the right ventricle
   c. Between the left atrium and left ventricle
   d. At the opening of the pulmonary artery

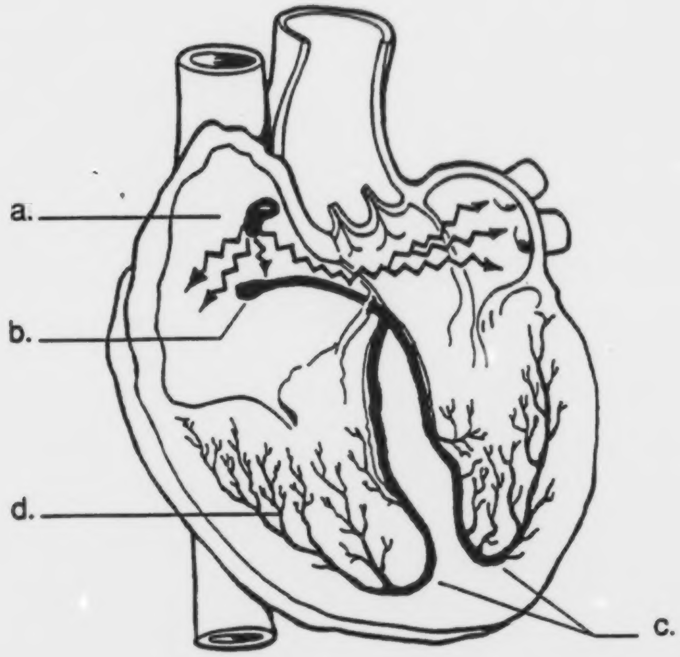
12. Locate the component parts of the heart conduction system.

___ AV node

___ Purkinje fibers

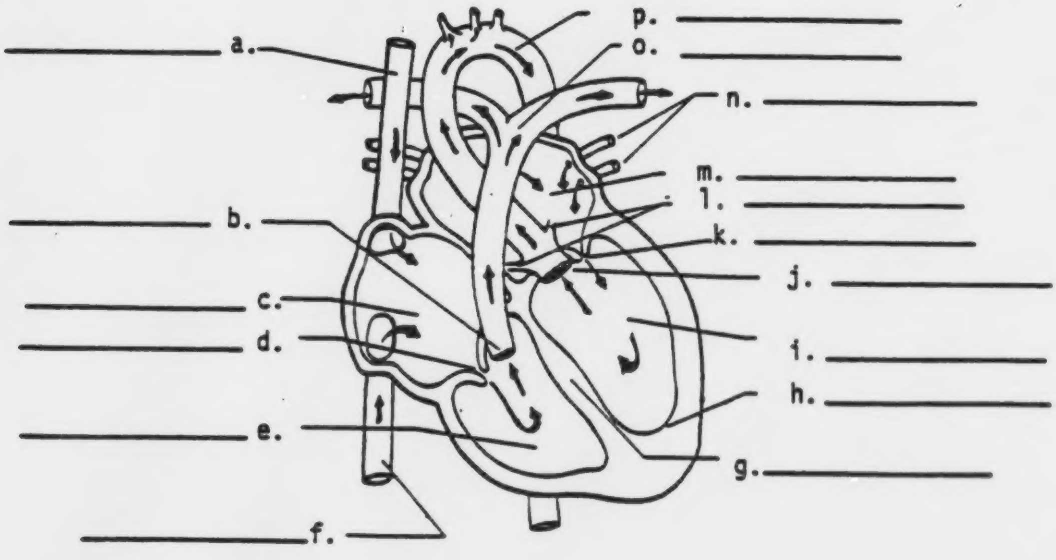
___ SA node

___ Bundle of His

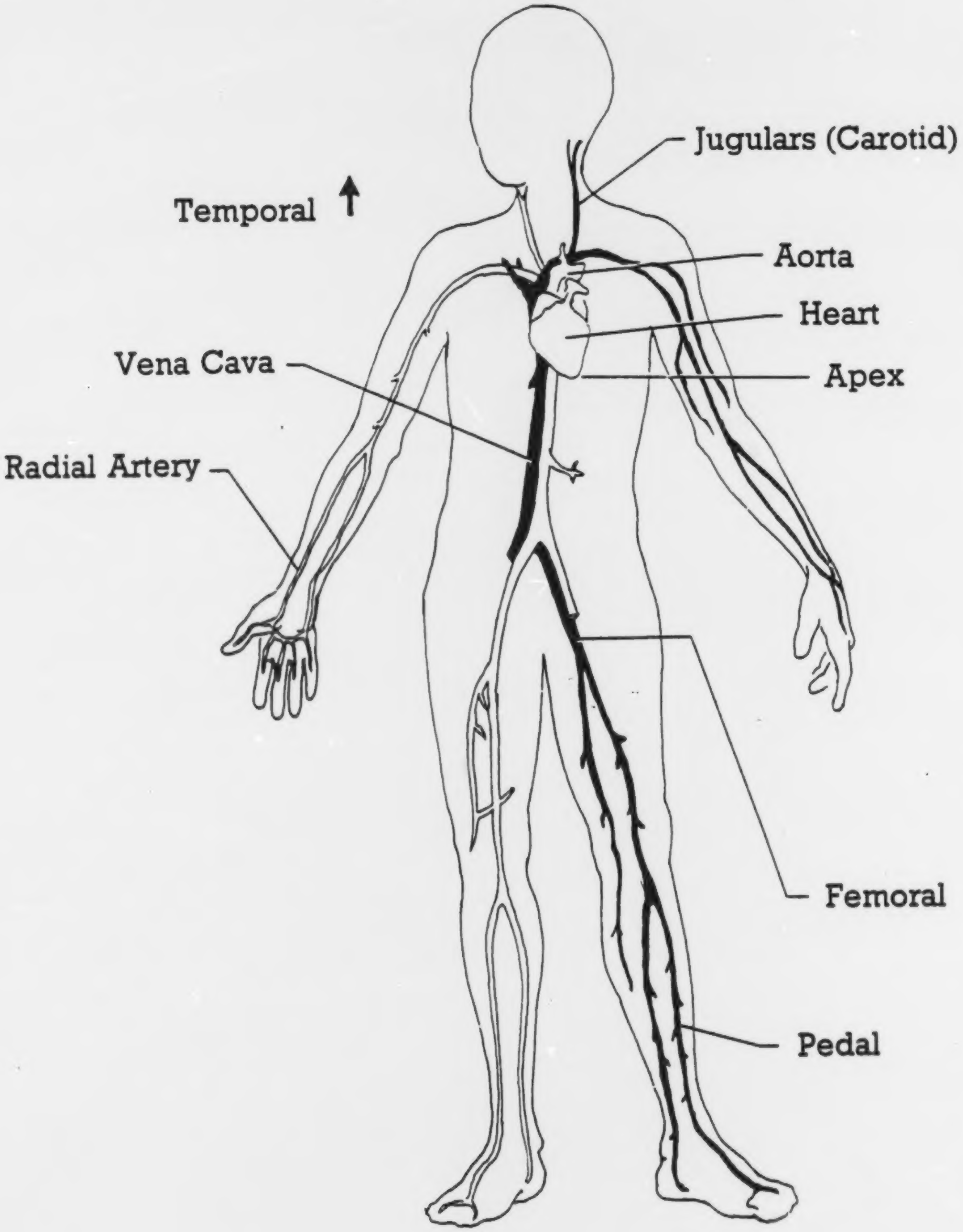


13. Trace the path of circulation on the diagram below, by labeling the parts on the diagram.

Vena cava
Aorta
Septum
Inferior vena cava
Right atrium
Left atrium
Pulmonary artery
Pulmonary semilunar valve
Endocardium
Mitral valve
Tricuspid valve
Right ventricle
Left ventricle
Pulmonary veins
Coronary arteries
Aortic semilunar valve

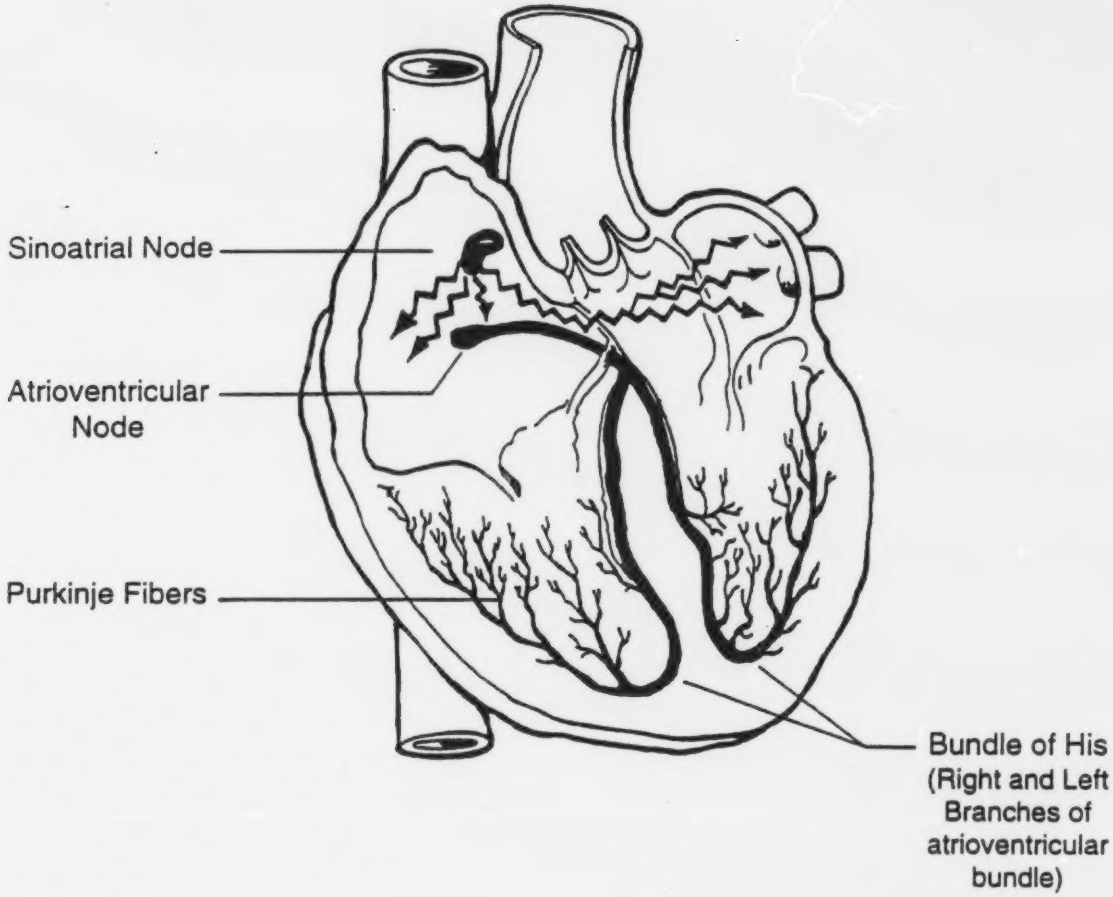


THE CARDIOVASCULAR SYSTEM

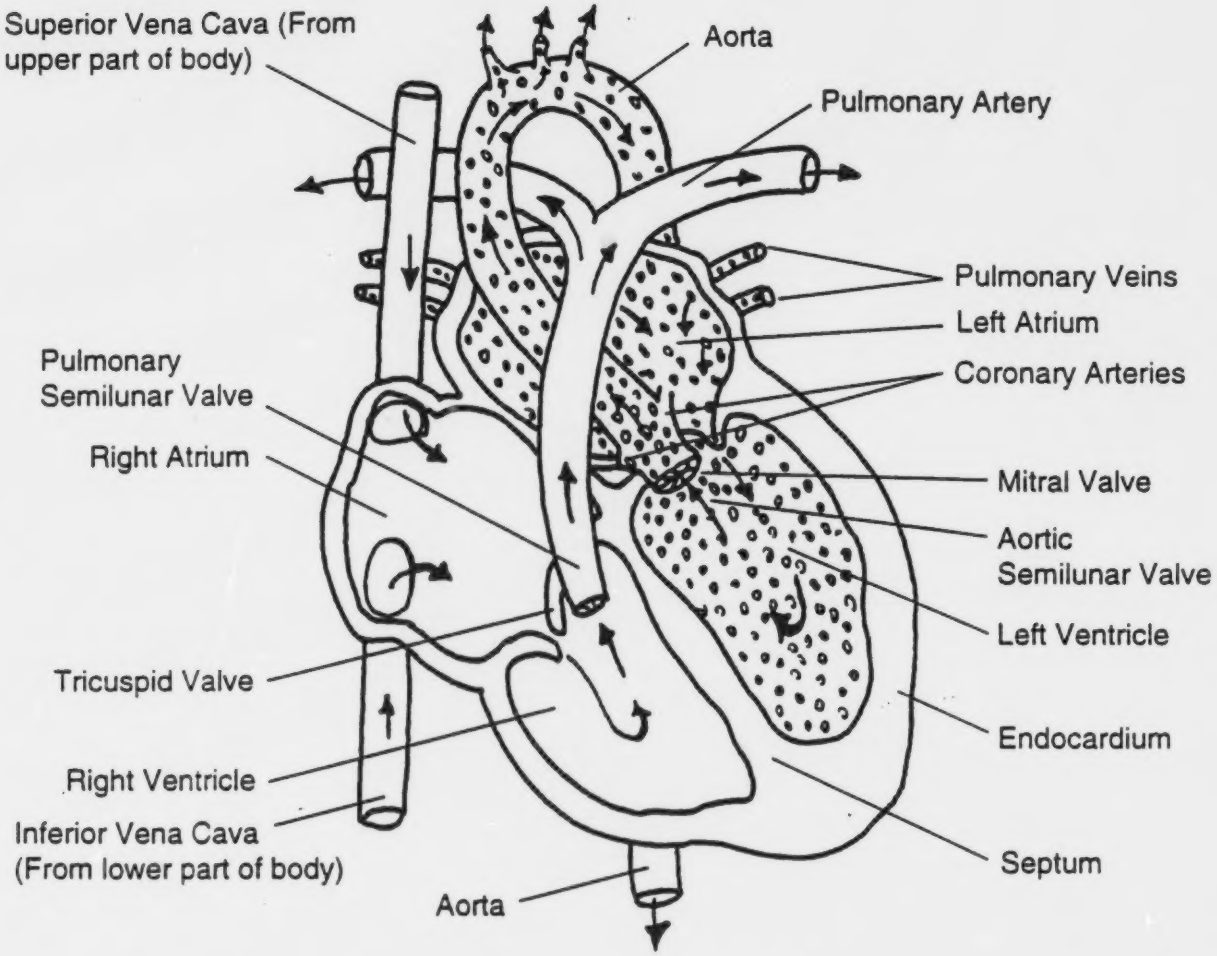

Jugulars (Carotid)
Temporal ↑
Aorta
Heart
Apex
Vena Cava
Radial Artery
Femoral
Pedal

908

CONDUCTION SYSTEM OF THE HEART


Sinoatrial Node
Atrioventricular Node
Purkinje Fibers
Bundle of His (Right and Left Branches of atrioventricular bundle)

PATH OF CIRCULATION


Superior Vena Cava (From upper part of body)
Aorta
Pulmonary Artery
Pulmonary Veins
Left Atrium
Coronary Arteries
Pulmonary Semilunar Valve
Right Atrium
Mitral Valve
Aortic Semilunar Valve
Left Ventricle
Tricuspid Valve
Endocardium
Right Ventricle
Inferior Vena Cava (From lower part of body)
Septum
Aorta

LESSON PLAN: 46

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX : THE CARDIOVASCULAR SYSTEM

SCOPE OF UNIT:

This unit examines the structure and function of the cardiovascular system, including the heart and circulation, the lymphatics, blood vessels, and blood. Medical terms and definitions relating to the cardiovascular system are included. Vital signs are also included in this unit.

INFORMATION TOPIC: IX-46 OR DEMONSTRATION:

CELLS, BLOOD TYPES, RH FACTOR, AND LYMPHATIC SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Name the three types of blood cells.
3. Identify the function of red blood cells.
4. Identify the function of white blood cells.
5. Identify the function of platelets.
6. Describe blood types.
7. Describe the RH factor.
8. Identify laboratory tests.
9. Describe the lymphatic system and its function.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Formed Elements
2. HO 2: Blood
3. HO 3: The Lymphatic System

4. HO 4: Lymph Nodes

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 46 (Student Reference page 735) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

Blood is the principle fluid of the heart and the circulatory system. It maintains homeostasis in the body. Blood is necessary for the survival of all body cells.

LESSON PLAN: 46

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX : THE CARDIOVASCULAR SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

  A. Cell - a definite unit in the organization of living substance, consisting of a small mass of protoplasm with a nucleus and surrounded by a membrane (the plasma, or cell, membrane)

  B. Plasma - liquid part of blood

  C. Hemoglobin - iron-containing protein in red blood cells

  D. Antigen - a substance that stimulates the body to make antibodies

  E. Anemia - red blood cell count drops below normal

  F. Polycythemia - bone marrow produces an excess of red blood cells

  G. Leukopenia - abnormally low white blood cell count

  H. Leukemia - malignant (cancer) disease which has with a large increase in the number of white cells

  I. Phagocytosis - ingestion and digestion of microbes by neutrophils and monocytes (part of white blood cells)

  J. Erythroblast - an immature red cell

  K. Erythrocyte - a red blood cell

  L. Hematocrit - the volume percentage of red cells to the whole blood (separation of red cells for counting)

  M. Lymphocyte - a white cell which is formed in the lymph glands

  N. Thrombocyte - a clotting cell

II. Blood Cells (HO 1) (II-2)

  A. Types

    1. Red blood cells - erythrocytes

2. White blood cells - leukocytes

3. Platelets - thrombocytes

B. Red and white blood cells are continually being destroyed. The body has to continually make new ones. Your body makes a few million red blood cells every second.

1. Myeloid tissue is found mainly in the sternum, ribs, hip bones, and cranial bones.

2. Myeloid tissue makes lymphatic tissue and blood cells for the body.

C. The lymphatic system forms lymphocytes and monocytes

III. Red Blood Cells - Erythrocytes

A. Characteristics

1. Have no nucleus

2. Cells are caved in on both sides so that each one has a thin center and thicker edge.

B. Function **(II-3)**

1. Transport oxygen from the lungs to all the body cells

2. Transport carbon dioxide from the body cells to the lungs

C. Number - 4 1/2 million to 5 million per cubic millimeter of blood

IV. White Blood Cells - Leukocytes

A. Characteristics

1. Colorless

2. Have nucleus

B. Types

1. Granulocytes

a. Neutrophils

b. Eosinophils

c. Basophils

2. Agranulocytes

a. Lymphocytes

b. Monocytes

C. Function

1. Fight microorganisms that have invaded the tissue and blood stream (II-4)

2. Neutrophils and monocytes engulf microbes. They take microbes into their cell bodies and digest the microbes.

3. When a microbe invades the body they stimulate lymphocytes to start multiplying and to be transformed into plasma cells which makes an antibody.

D. Number - 5,000 to 10,000 per cubic millimeter of blood

V. Platelets - Thrombocytes

A. Characteristics - form a chain reaction to cause blood to clot.

B. Function - clotting of blood (II-5)

1. If you have an injury to a blood vessel, there will be a rough spot in the blood vessel.

2. As the platelets flow over the rough spot, they release a substance that causes the formation of the platelet factor.

3. The platelets then become "sticky" and form over the opening of the blood vessel where the injury is located.

4. Next the platelet factor combines with prothrombin, calcium, and other substance, to form thrombin.

5. The thrombin reacts with fibrinogen to form fibrin.

6. The fibrin causes the blood to clot.

C. Produced in red bone marrow

D. Number - 250,000 to 500,000 per cubic millimeter of blood

E. Some causes of bleeding

1. Deficiency of platelets

2. Vitamin K deficiency

3. Deficiency of vitamin C

4. Anticoagulant drugs

5. Erosion of blood vessel

VI. Blood Types (HO 2)

A. Blood type is identified by the presence of the red blood cells of certain antigens.

1. The antigen stimulates the body to make antibodies.

2. The antibodies react with antigens to clump or stick together.

B. According to types

1. Type A - (41% of Americans have this type.) You were born with Type A antigen and your body does not form antibodies to react with it. Type A blood contains Type A antigen in red blood cells and anti- B antibodies in the plasma.

2. Type AB - (universal recipient) The red blood cells contain both A and B antigens and the plasma does not contain the anti- A or anti- B antibodies. **(II-6)**

3. Type O - (universal donor) The red blood cells do not contain type A or type B antigens and the plasma does contain anti- A and anti-B antibodies. **(II-7)**

4. Type B - Contains Type B antigen in red blood cells and Anti-A antibodies in the plasma.

VII. RH Factor

A. RH positive blood - the red blood cells contain an antigen called the RH factor. **(II-8)**

B. RH negative blood - the red blood cells do not contain the RH factor. **(II-9)**

C. Erythroblastosis - occurs when the mother is RH negative and the father is RH positive.

VIII. Laboratory Tests **(II-10)**

A. Blood counts

1. CBC - complete blood count

        2. WBC - white blood cell count

        3. RBC - red blood cell count

        4. HB - hemoglobin count

    B. Bleeding time

    C. Blood chemistry

    D. Serology

    E. Blood type - cross matching

IX. Lymphatic System (HOs 3 & 4)

    A. Description

        1. Part of the circulatory system

        2. Consist of a fluid called lymph

        3. Lymph fluid comes from the blood and returns to the blood by way of the lymphatic vessels.

        4. This system includes:

            a. Lymph

            b. Lymphatic vessels

            c. Lymph nodes

            d. Thymus

            e. Spleen

    B. Function of lymph - transports tissue fluid, proteins, fats and other substance to the general circulation (II-11)

        1. Lymph nodes (lymph glands)

        2. Description

            a. Oval in shape

            b. Size varies from the size of a pinhead to the size of a bean.

        3. Function

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        - a. As lymph passes through the lymph node it filters harmful particles, removes them, and prevents them from entering the blood and circulating to other parts of the body.
        - b. They form white blood cells - lymphocytes, monocytes, and granular white blood cells.
    - 4. Located
        - a. Throughout the body in clusters; for example groin, and axilla
- C. Lymphatic organs
    - 1. Spleen
        - a. Located in the upper left corner of the abdominal cavity just under the diaphragm
        - b. Connects with blood vessels and nerves
        - c. Function
            - (1) Forms lymphocytes and monocytes
            - (2) Stores blood and can release it back into circulation when needed
    - 2. Tonsils and adenoids
        - a. Location - located in posterior portion of nasopharynx
        - b. Function - unknown - thought to fight infection
    - 3. Thymus gland
        - a. Located - below the parathyroid gland: found only in children
        - b. Function - produce lymphocytes and establishes antibody formation in newborn

X. Summary and Conclusion

- A. Terms and definitions
- B. Blood cells
- C. Red blood cells - erythrocytes
- D. White blood cells - leukocytes

E. Platelets - thrombocytes

F. Blood types

G. RH factor

H. Laboratory tests

I. Lymphatic system

In this lesson, blood cells, types of blood cells, the RH factor and lymphatic system were discussed. The next lesson will be blood vessels.

LESSON PLAN: 46

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

INTERACTION ITEMS:

1. **What are the definitions of terms used in this lesson?**
2. **What are the three types of blood cells?**
3. **What is the function of red cells?**
4. **What is the function of white cells?**
5. **What is the function of platelets?**
6. **What type of blood is a universal recipient?**
7. **What type of blood is a universal donor?**
8. **What does RH positive blood mean?**
9. **What is meant by RH negative blood?**
10. **What are the following laboratory tests: CBC, WBC, RBC, and Hb?**
11. **What is the function of lymph nodes?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Obtain blood typing kits and have students type their own blood.**
2. **Visit a blood bank or have representative from blood bank speak to class.**
3. **Assign reports on blood disorders.**

ANSWERS TO EVALUATION ITEMS:

1. **b**
2. **d**
3. **e**
4. **a**
5. **c**
6. **Red blood cells, white blood cells, platelets**
7. **c**

8. b
9. Positive
10. d
11. c

LESSON PLAN: 46

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definition in Column II.

Column I	Column II
____ 1. Plasma	a. The volume percentage of red cells to the whole blood
____ 2. Antigen	b. Liquid part of blood
____ 3. Polycythemia	c. Ingestion and digestion of microbes by neutrophils and monocytes
____ 4. Hematocrit	d. A substance that stimulates the body to make antibodies
____ 5. Phagocytosis	e. Bone marrow produces an excess of red blood cells
	f. Iron-containing protein in red blood cells

6. Name the three types of blood cells.

   a.

   b.

   c.

7. What is the function of red blood cells? (Circle the letter of the best answer.)

   a. Clotting of blood
   b. Fight microorganisms
   c. Transport oxygen and carbon dioxide
   d. Fight infection

8. A universal recipient has what type of blood? (Circle the letter of the best answer.)

   a. Type A
   b. Type AB
   c. Type O
   d. Type B

9. The red blood cells contain an antigen called the RH factor in RH
_________________________ blood.

10. Which abbreviation means a complete blood cell count? (Circle the letter of the best answer.)

    a. WBC
    b. RBC
    c. Hb
    d. CBC

11. What is the function of lymph nodes? (Circle the letter of the best answer.)

    a. Transport food and oxygen
    b. To keep blood from flowing backward
    c. Filter harmful particles and form white blood cells
    d. Act as a conduction system

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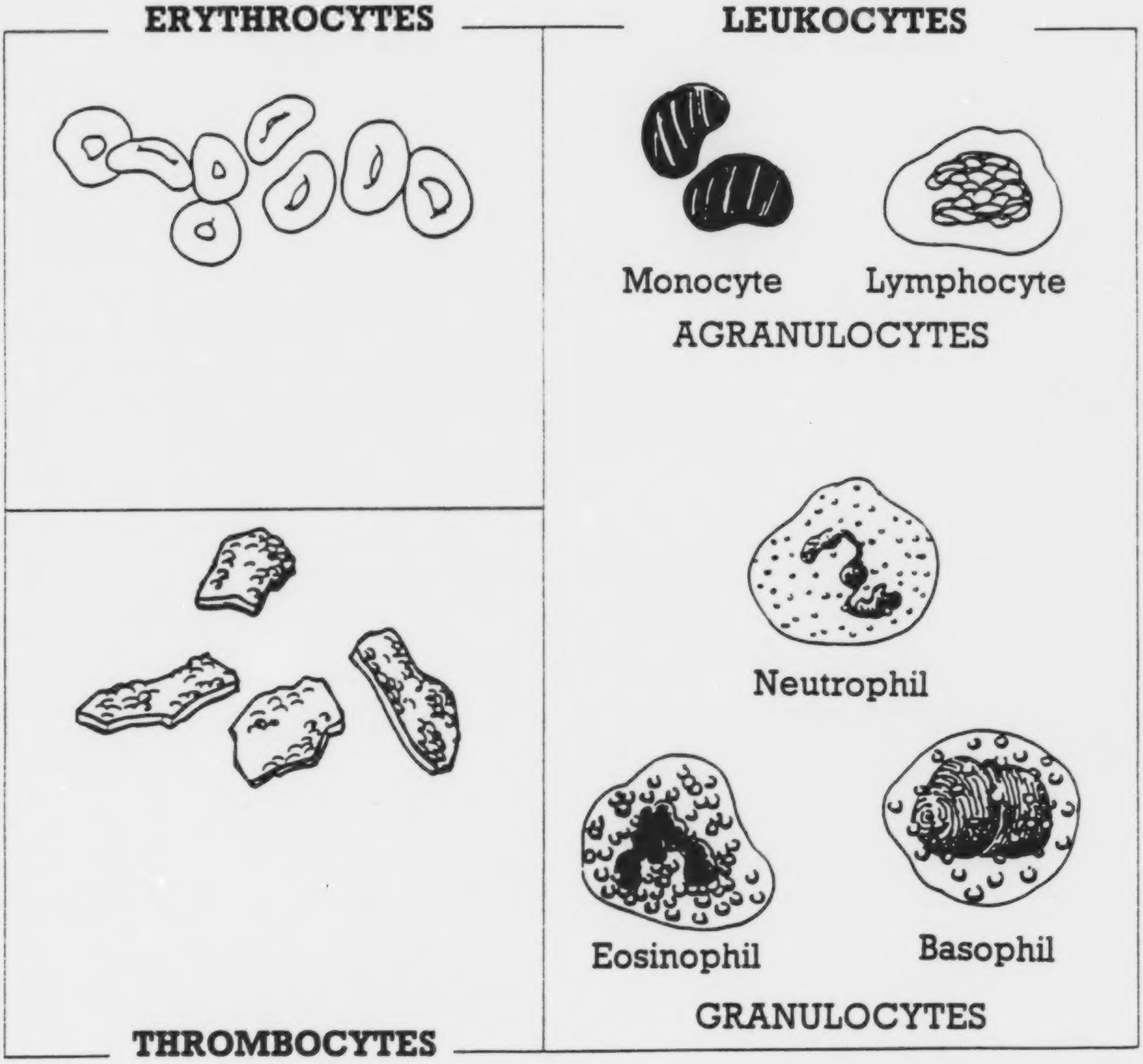
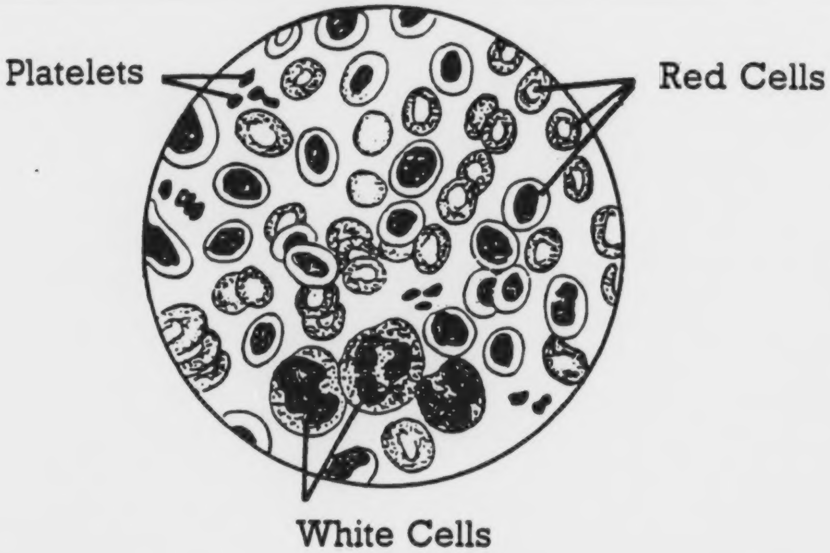
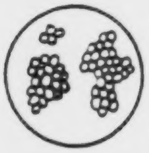
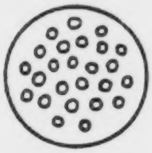
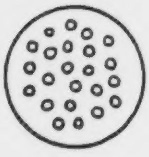
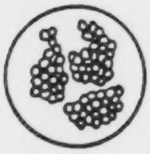
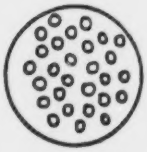
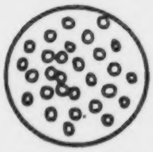
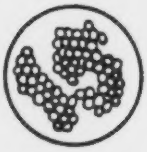
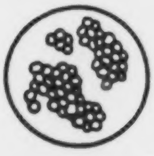
HO 1

FORMED ELEMENTS


ERYTHROCYTES
LEUKOCYTES
Monocyte
Lymphocyte
AGRANULOCYTES
Neutrophil
Eosinophil
Basophil
GRANULOCYTES
THROMBOCYTES

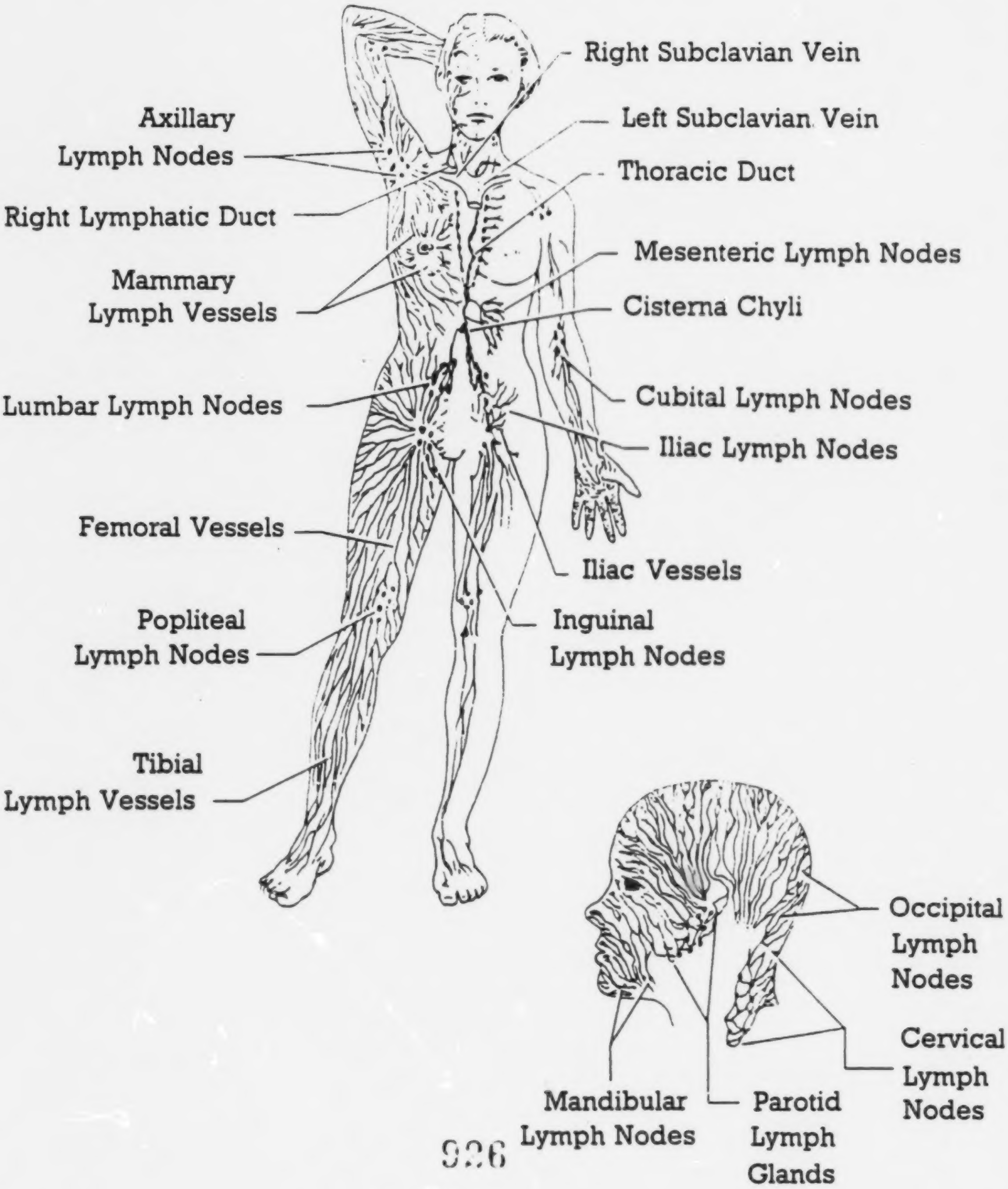
BLOOD


Platelets
Red Cells
White Cells

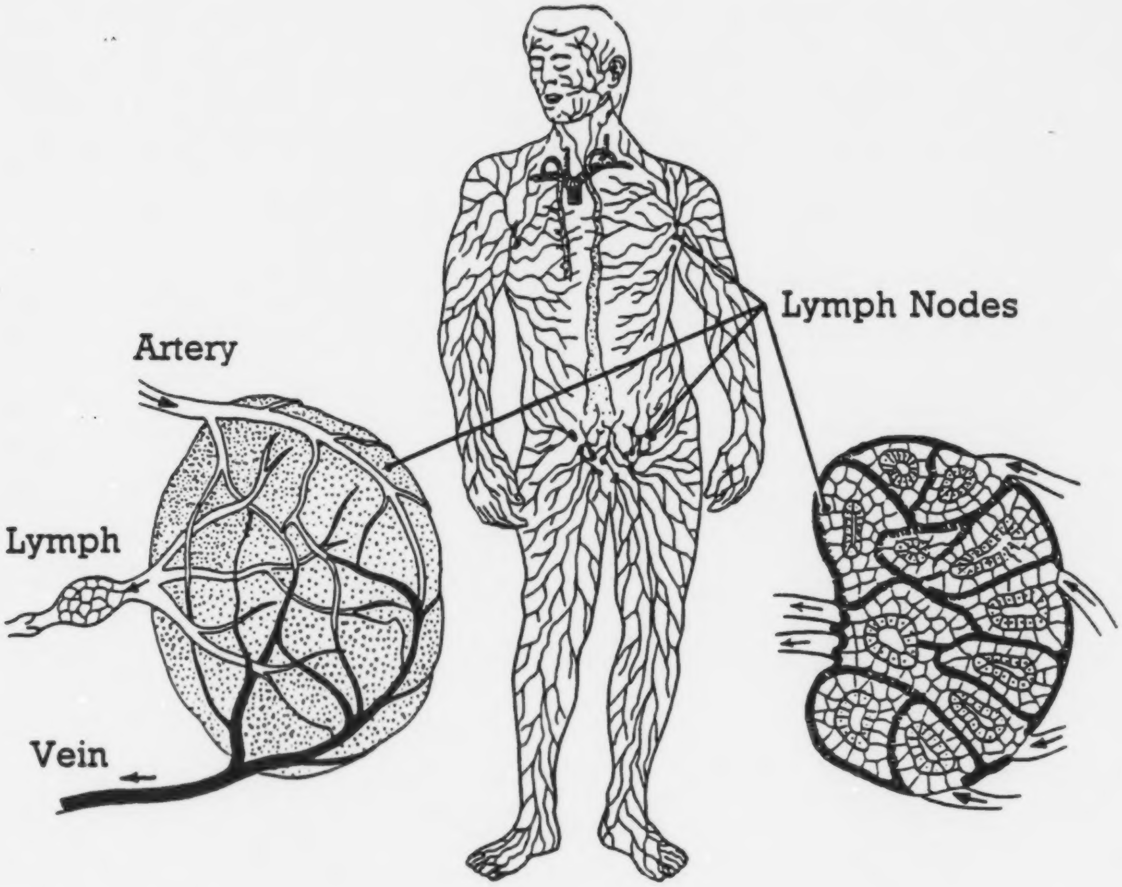
TYPE	Anti-A	Anti-B
A		
B		
O		
AB		

THE LYMPHATIC SYSTEM

LYMPH NODES AND VESSELS OF THE HEAD AND BODY


Right Subclavian Vein
Left Subclavian Vein
Axillary Lymph Nodes
Thoracic Duct
Right Lymphatic Duct
Mesenteric Lymph Nodes
Mammary Lymph Vessels
Cisterna Chyli
Cubital Lymph Nodes
Lumbar Lymph Nodes
Iliac Lymph Nodes
Femoral Vessels
Iliac Vessels
Popliteal Lymph Nodes
Inguinal Lymph Nodes
Tibial Lymph Vessels
Occipital Lymph Nodes
Cervical Lymph Nodes
Mandibular Lymph Nodes
Parotid Lymph Glands

LYMPH NODES


Lymph Nodes
Artery
Lymph
Vein

LESSON PLAN: 47

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

SCOPE OF UNIT:

This unit examines the structure and function of the cardiovascular system, including the heart and circulation, the lymphatics, blood vessels, and blood. Medical terms and definitions relating to the cardiovascular system are included. Vital signs are also included in this unit.

INFORMATION TOPIC: IX-47 OR DEMONSTRATION:

BLOOD VESSELS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Identify blood vessels, their structure, and function.
3. Describe blood pressure.
4. Identify areas where a pulse may be taken.
5. Identify types of circulation.
6. Describe valvular, coronary, and vascular disease and condition.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Blood Vessels
2. HO 2: Arteries
3. HO 3: Veins
4. HO 4: General or Systemic Circulation
5. HO 5: Pulmonary Circulation
6. HO 6: Fetal Circulation

7. Wall Chart of the Heart

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 47 (Student Reference page 749) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

The circulatory system maintains homeostasis by acting as a transportation system. Food and oxygen are conveyed from the digestive system and respiratory system to all the body cells. Waste products are removed from the cells by the circulatory system and disposed of through the kidneys, lungs, and skin where they are excreted. The three main blood vessels in the body are arteries, veins, and capillaries.

LESSON PLAN: 47

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

- A. Arteriole - small branch of an artery
- B. Artery - blood vessel that carries blood away from the heart
- C. Arteriosclerosis - hardening of the arteries
- D. Capillary - blood vessel that connects arterioles with venules, microscopic in size
- E. Diastole - the dilation stage of the cardiac cycle
- F. Endothelium - epithelial cells; they line closed body cavities, blood vessels, and heart and lymph vessels
- G. Pulse - alternating expansion and contraction of an artery as blood flows through it
- H. Valve - a structure that allows the flow of blood or fluid in only one direction
- I. Systolic blood pressure - pressure at the moment of contraction
- J. Diastolic blood pressure - the force when the ventricles are relaxed
- K. Venules - tiny veins
- L. Interstitial fluid - intercellular connective tissue fluid

II. Blood Vessels (HO 1) **(II-2, 3)**

- A. Arteries
  - 1. Description
    - a. Arteries are elastic and muscular and have thick walls. They are the strongest of the three main types of blood vessels.
    - b. Arteries transport blood under high pressure. **(II-4)**

2. Function

   a. All arteries carry blood away from the heart.

   b. All arteries carry oxygenated blood except the pulmonary arteries. The pulmonary arteries carry deoxygenated blood from the heart to the lungs.

3. Structure - three wall layers

   a. Tunica adventitia or externa - outer layer **(II-5)**

   b. Tunica media - middle layer - this layer regulates the blood flow through the artery

   c. Tunica intima - inner layer

4. Distribution

   a. The pulmonary trunk and aorta lead away from the heart.

   b. They branch into smaller arteries.

   c. Smaller arteries branch into arterioles.

   d. Arterioles branch into capillaries.

5. Arteries of the body (HO 2)

B. Capillaries

1. Description

   a. They are so small they can only be seen through a microscope. **(II-6)**

   b. They connect arterioles with venules.

2. Structure

   a. Capillaries are simple endothelial cells.

   b. The walls are very thin.

3. Function

   a. They are exchange vessels.

   b. Glucose and oxygen move out of the blood in the capillaries into interstitial fluid and into cells.

c. Carbon dioxide moves into the capillary blood from the cells.

d. Fluid is exchanged between capillary blood and interstitial fluid.

e. Ultimately, capillaries are responsible for transporting blood to all of the body's tissues.

C. Veins (HO 3)

1. Description

a. Veins carry blood back to the heart.

b. Veins carry deoxygenated blood except the four pulmonary veins **(II-7)**

c. The pulmonary veins carry oxygenated blood away from the lungs to the heart.

2. Structure

a. They contain a muscular layer but are less elastic and muscular than arteries.

b. Walls are thinner than the walls of arteries.

c. Veins have valves which allows the blood to flow in only one direction.

3. Function - Carry blood back to the heart

4. Distribution

a. Venules converge to make up larger veins.

b. The larger veins form the body's largest vein, the vena cava.

c. Return of venous blood to the heart:

(1) Upper part of the body by the superior vena cava to the right atrium

(2) Lower part of the body by the inferior vena cava to the right atrium

III. Blood Pressure

A. Blood pressure is the pressure or push of blood against the walls of arteries. **(II-8)**

B. The purpose of blood pressure is to keep the blood flowing.

C. High blood pressure can cause the rupture of blood vessels.

D. If your blood pressure falls low enough, circulation and life can cease - example - hemorrhage.

E. The cause of blood pressure is the volume of blood in the blood vessels.

IV. Pulse (II-9)

A. Pulse is the vibration (expansion or contraction) of the blood in the arteries as the heart beats.

B. To feel a pulse, you place your fingertips over an artery that is near the surface of the body and over a bone or other firm surface.

C. Six areas to take a pulse

1. Radial artery - at the wrist, posterior surface of the radius
2. Temporal artery - above and to the outer side of the eye, in front of the ear
3. Common carotid artery - in the neck along the front margin of the sternocleidomastoid muscle, near the lower margin of the thyroid cartilage
4. Facial artery - at lower edge of the mandible, near the corners of the mouth
5. Brachial artery - at the bend of the elbow, along the inner border of the biceps muscle
6. Dorsalis pedis artery - at the front of the foot, below the ankle joint

V. Types of Circulation (II-10)

A. Systemic circulation - flow of blood from the left ventricle throughout the body as a whole (HO 4)

B. Pulmonary circulation - flow of blood from the right ventricle to the lung (HO 5)

C. Portal circulation - circulation of blood through the liver

D. Renal circulation - circulation of blood from the aorta through the renal artery to the kidney and then by way of the renal vein back into the inferior vena cava and then the heart

E. Fetal circulation (HO 6)

F. Coronary circulation - circulation of blood to the heart muscle

VI. Valvular, Coronary, and Vascular Diseases and Conditions **(II-11)**

A. Rheumatic fever - the cause is unknown, but it is thought to be related to upper respiratory infection (streptococcus). It can lead to permanent damage to the heart and valves.

B. Endocarditis - It is an inflammation of the lining of the heart and lining of the heart valves.

C. Mitral insufficiency - valves do not close completely.

D. Angina pectoris - blood supply to heart does not meet the heart's needs; causes severe chest pain.

E. Hypertension - (high blood pressure) - a systolic pressure of 150 mm Hg or above and a diastolic pressure of 90 mg Hg is considered to be high blood pressure.

F. Arteriosclerosis - hardening of the arteries

G. Varicose veins - dilated, tortuous veins: blood collects in these veins and cannot be returned efficiently to the heart.

H. Thrombophlebitis - inflammation of a vein

I. Embolism - blood clot in a vein

J. Leukemia - cancer of the blood

K. Myocardial infarction - obstruction of a blood vessel in the heart muscle, which results in death of heart tissue due to the lack of oxygen

L. Anemia - decrease in the quality and quantity of red blood cells

M. Cerebral vascular accident (stroke) - caused by a blockage or rupture of arteries in the brain

N. Congestive heart failure - heart is unable to pump enough blood for the body

VII. Summary and Conclusion

A. Terms and definitions

B. Blood vessels

C. Blood pressure

D. Pulse

E. Valvular, coronary, and vascular diseases and conditions

This lesson discussed types of blood vessels, types of circulation, pulse, and valvular, coronary and vascular diseases and conditions. In your next lesson we will discuss blood pressure.

LESSON PLAN: 47

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

INTERACTION ITEMS:

1. What are the definitions of diastolic pressure, valve, arteriole, and artery?
2. What are the three main types of blood vessels?
3. What is the structure of the three types of blood vessels?
4. What blood vessel carries oxygenated blood?
5. What are the names of the three layers of the arterial wall?
6. What blood vessel connects arterioles with venules?
7. What blood vessel carries deoxygenated blood?
8. What causes blood pressure?
9. What areas of the body can a pulse be taken?
10. What are the six types of circulation?
11. What is the description of each of the following: angina pectoris, hypertension, arteriosclerosis, varicose veins, embolism, and cerebral vascular accident?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. American Heart Association Literature and Films
2. Cardiopulmonary resuscitation (CPR) course (8 hours)
3. Assign short report topics such as varicose veins, arteriosclerosis, etc., for classroom presentations.
4. Panel discussion on "How Lifestyle Affects Blood Pressure and Pulse."

ANSWERS TO EVALUATION ITEMS:

1. d
2. a
3. e

4. f
5. c
6. c
7. a
8. b
9. b
10. a
11. d
12. a
13. c
14. b
15. c
16. b
17. c
18. a
19. d
20. b
21. c
22. e
23. f
24. a
25. b
26. d

LESSON PLAN: 47

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with their correct definitions in Column II.

Column I	Column II
___ 1. Diastolic pressure	a. A structure which allows the flow of blood or fluid in only one direction
___ 2. Valve	b. Blood pressure at the moment of contraction
___ 3. Venules	c. Blood vessel which carries blood away from the heart
___ 4. Arteriole	d. The force when the ventricles are relaxed
___ 5. Artery	e. Tiny veins
	f. Small branch of an artery

Match the following blood vessels in Column I with their correct descriptions in Column II.

Column I	Column II
___ 6. Arteries	a. Connect arterioles to venules
___ 7. Capillaries	b. Carry deoxygenated blood
___ 8. Veins	c. Carry oxygenated blood

9. The tunica media is which layer of the arterial wall? (Circle the letter of the best answer.)

   a. Outer layer
   b. Middle layer
   c. Inner layer
   d. Third layer

10. __________________ walls are very thin. (Circle the letter of the best answer.)

a. Capillaries
b. Arteries
c. Arterioles
d. Veins

11. __________________ have valves which allow blood to flow in only one direction. (Circle the letter of the best answer.)

a. Capillaries
b. Arteries
c. Arterioles
d. Veins

12. Arterioles branch into: __________________ (Circle the letter of the best answer.)

a. Capillaries
b. Arteries
c. Arterioles
d. Veins

13. What moves into the capillary blood from cells? (Circle the letter of the best answer.)

a. Oxygen
b. Carbon dioxide
c. Carbon monoxide
d. Glucose

14. The largest vein in the body is the __________________. (Circle the letter of the best answer.)

a. Aorta
b. Vena cava
c. Venules
d. Pulmonary

15. Which one of the following is a correct description of blood pressure? (Circle the letter of the best answer.)

a. Blood pressure is the pressure or push of blood against the walls of veins.
b. Blood pressure is the pressure or push of blood against the walls of capillaries.
c. Blood pressure is the pressure or push of blood against the walls of arteries.
d. Blood pressure is the pressure or push of blood against the walls of venules.

16. An area where the pulse can be taken is: (Circle the letter of the best answer.)

- a. At the bottom of the foot above the ankle
- b. At the wrist posterior surface of the radius
- c. Behind the ear and under the eye
- d. Above the elbow, along the outer border of the biceps muscle

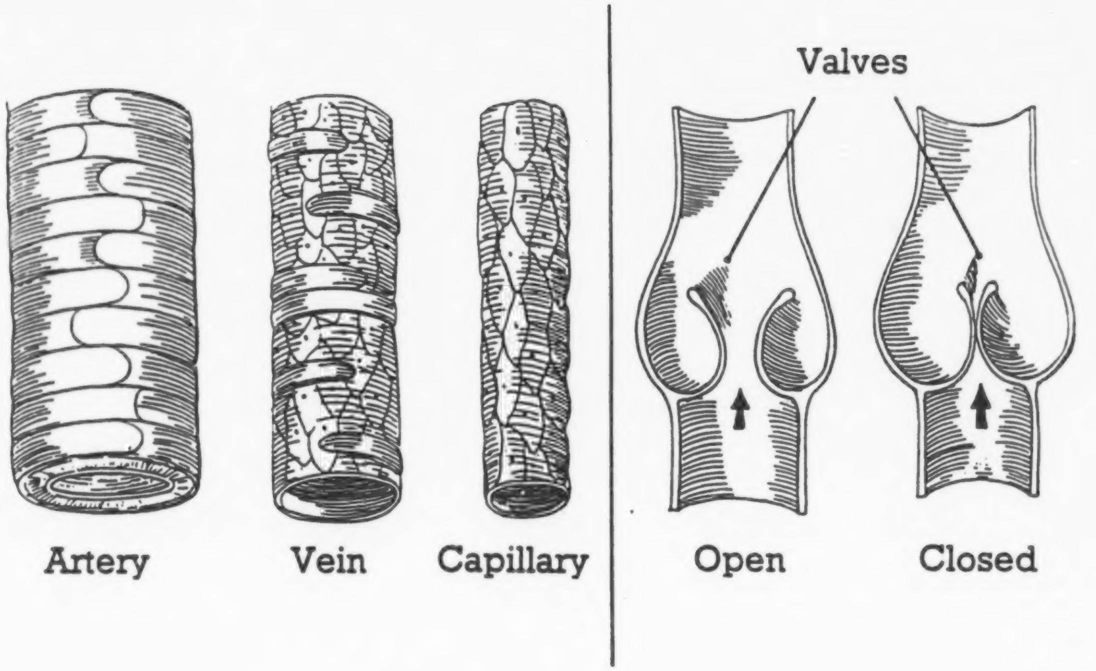
Match the type of circulation in Column I with the correct description in Column II.

Column I	Column II
____ 17. Coronary	a. Flow of blood from the left ventricle throughout the body as a whole
____ 18. Systemic	
	b. Circulation of blood through the liver
____ 19. Pulmonary	
	c. Circulation of blood from right ventricle to the lungs
____ 20. Portal	
	d. Circulation of blood through the liver

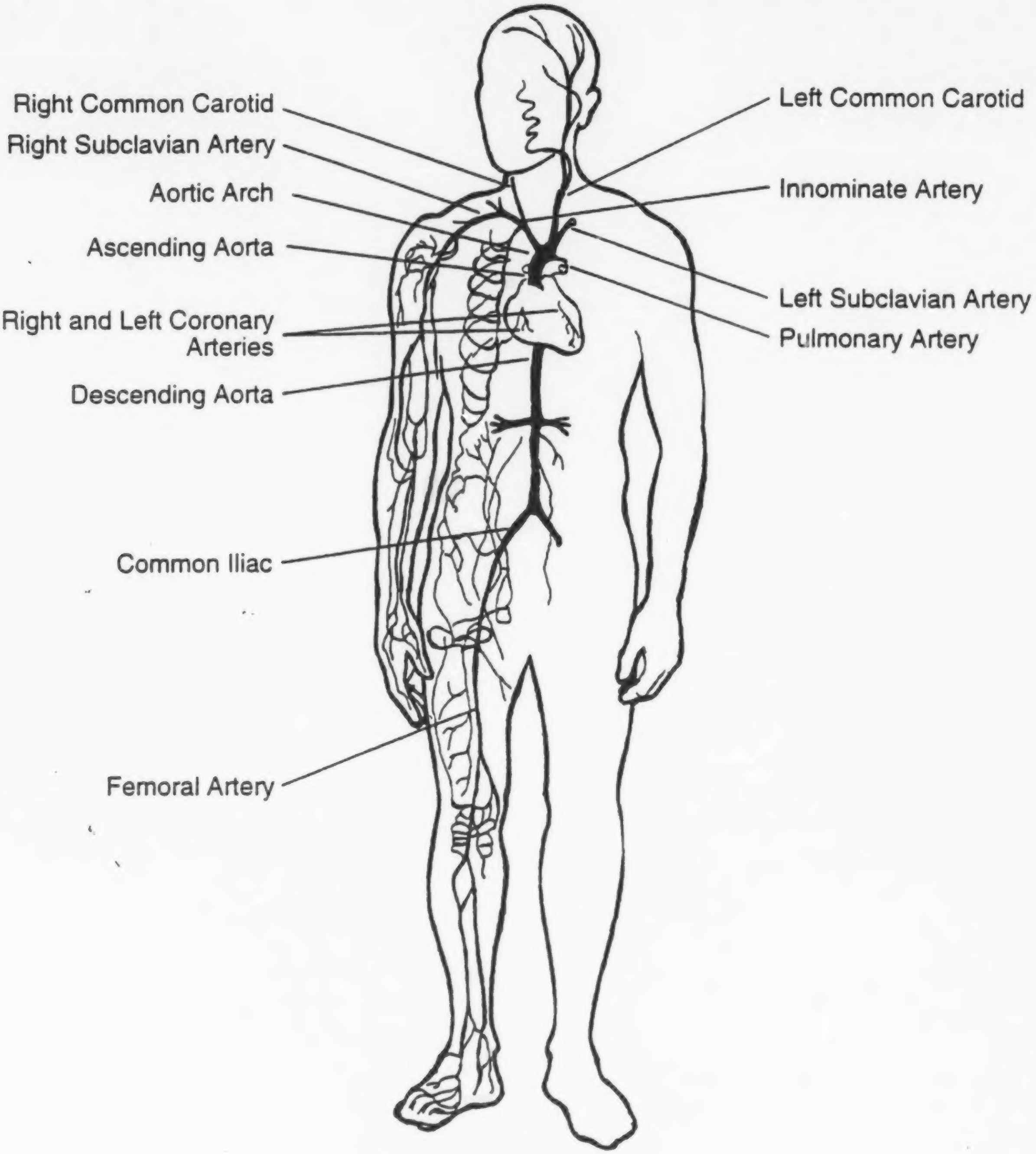
Match the disease or condition in Column I with the correct description in Column II.

Column I	Column II
____ 21. Angina pectoris	a. Dilated, tortuous veins
____ 22. Hypertension	b. Blood clot in a vein
____ 23. Arteriosclerosis	c. Blood supply to the heart does not meet the hearts needs
____ 24. Varicose veins	
	d. Caused by a blockage or rupture of arteries in the brain
____ 25. Embolism	
____ 26. Cerebral vascular accident	e. High blood pressure
	f. Hardening of the arteries

BLOOD VESSELS


Valves
Artery
Vein
Capillary
Open
Closed

ARTERIES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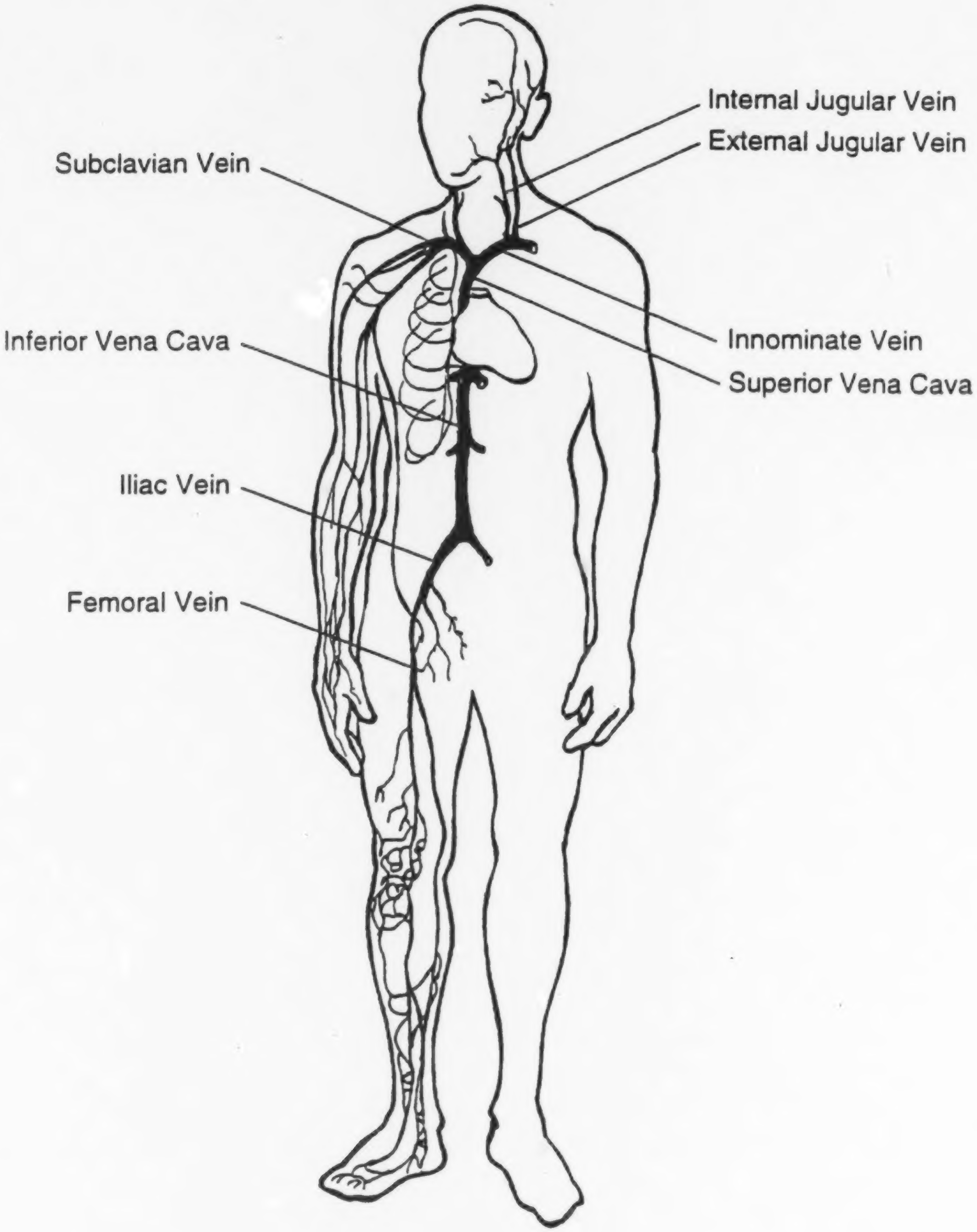
Right Subclavian Artery
Aortic Arch
Ascending Aorta
Right and Left Coronary Arteries
Descending Aorta
Common Iliac
Femoral Artery
Left Common Carotid
Innominate Artery
Left Subclavian Artery
Pulmonary Artery

VEINS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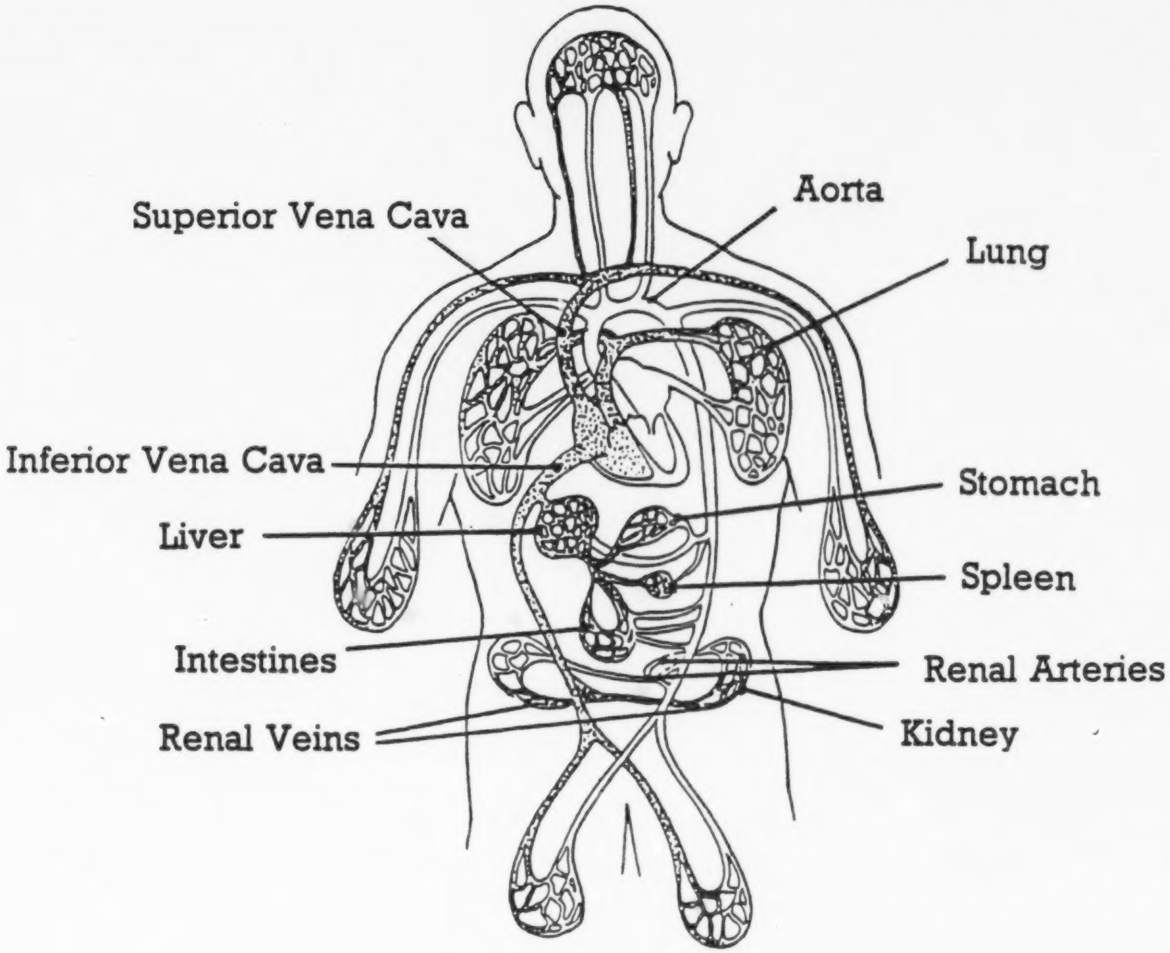
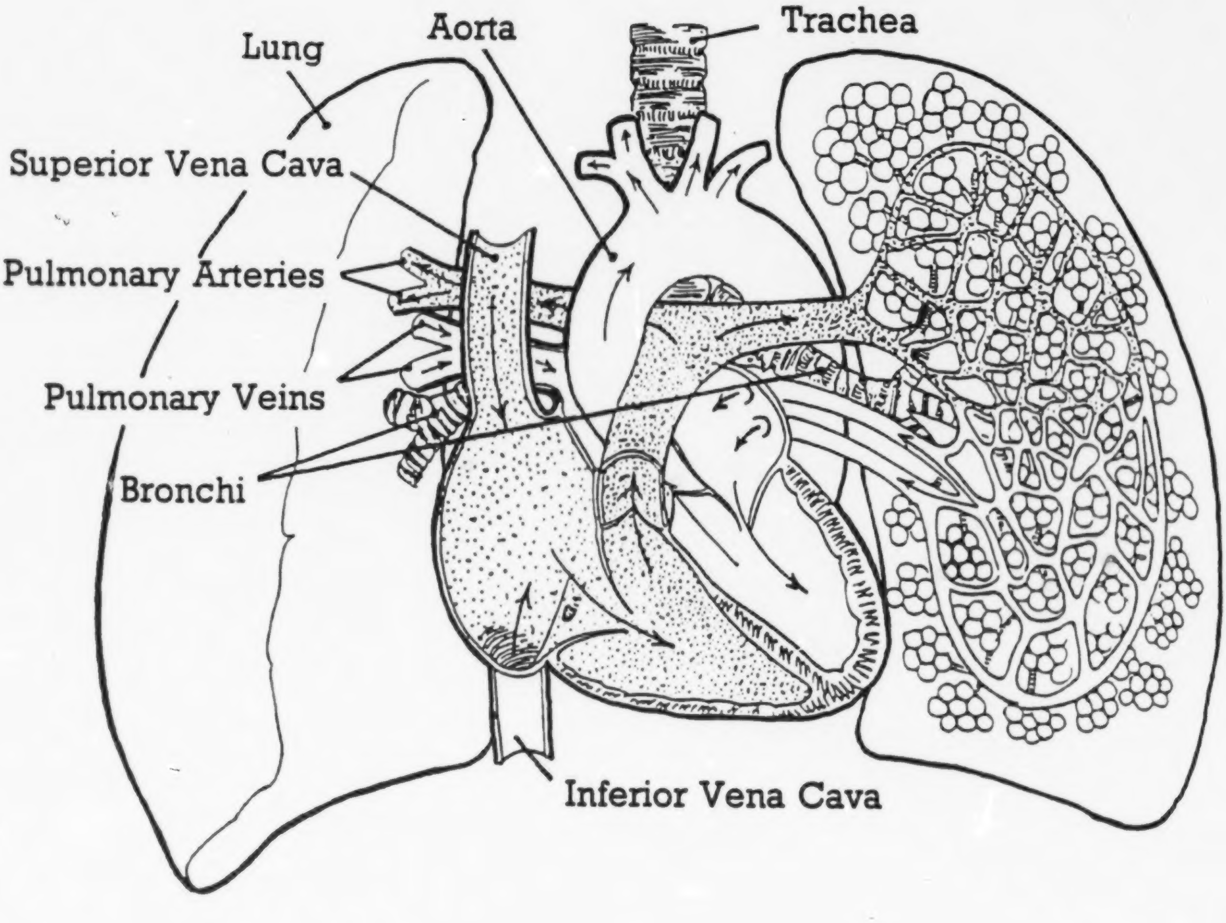
External Jugular Vein
Subclavian Vein
Inferior Vena Cava
Innominate Vein
Superior Vena Cava
Iliac Vein
Femoral Vein

GENERAL OR SYSTEMIC CIRCULATION


Superior Vena Cava
Aorta
Lung
Inferior Vena Cava
Stomach
Liver
Spleen
Intestines
Renal Arteries
Renal Veins
Kidney

PULMONARY CIRCULATION


Lung
Aorta
Trachea
Superior Vena Cava
Pulmonary Arteries
Pulmonary Veins
Bronchi
Inferior Vena Cava

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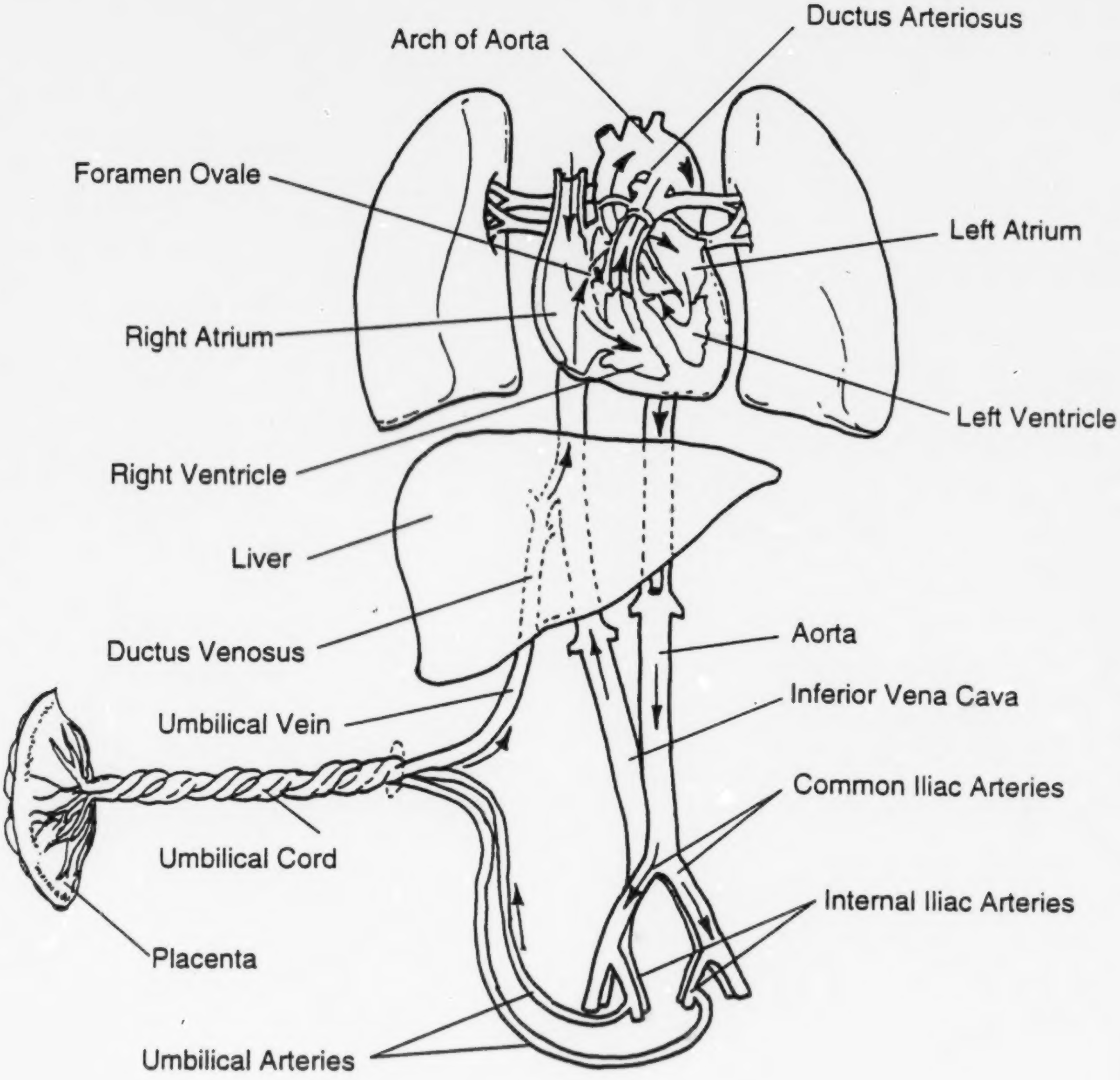
FETAL CIRCULATION


Arch of Aorta
Ductus Arteriosus
Foramen Ovale
Left Atrium
Right Atrium
Left Ventricle
Right Ventricle
Liver
Ductus Venosus
Aorta
Inferior Vena Cava
Umbilical Vein
Common Iliac Arteries
Umbilical Cord
Internal Iliac Arteries
Placenta
Umbilical Arteries

LESSON PLAN: 48

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

SCOPE OF UNIT:

This unit examines the structure and function of the cardiovascular system, including the heart and circulation, the lymphatics, blood vessels, and blood. Medical terms and definitions relating to the cardiovascular system are included. Vital signs are also included in this unit.

INFORMATION TOPIC: IX-48 AND DEMONSTRATION: IX-48

BLOOD PRESSURE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. Distinguish between systolic and diastolic blood pressures.
3. Identify the normal range for systolic blood pressure.
4. Identify the normal range for diastolic blood pressure.
5. Identify equipment used to take a blood pressure.
6. Identify key points in measuring blood pressure.

Demonstration

7. Measure blood pressure according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Reading a Mercury Sphygmomanometer
2. HO 2: Reading an Aneroid Sphygmomanometer
3. HO 3: Proper Position for Taking Blood Pressure
4. Measuring Assistant Techniques Measuring: Pulse, Respiration, and Blood Pressure, video #3, available from the Missouri Vocational Resource Center, 12 min.

5. Television and VCR
6. Sphygmomanometer with blood pressure cuff
7. Stethoscope
8. Alcohol sponges
9. Note pad and pencil

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 48 (Student Reference page 765) prior to class and be prepared to discuss the information presented and return the demonstration on taking a blood pressure.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 17.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 4, Section 4.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publishers, 1992. Unit 16.

INTRODUCTION:

Blood pressure is one of the vital signs. This procedure requires an understanding of what you are actually listening to and familiarity with the equipment used. Certain factors can alter the reading, thus producing an inaccurate measurement. Treatment can be based on BP readings which, if not read correctly, could result in harm to the client. You must practice taking blood pressure readings to become proficient.

LESSON PLAN: 48

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

   A. Blood pressure - the amount of force exerted against the walls of an artery by the blood

   B. Diastolic pressure - the pressure in the arteries when the heart is at rest

   C. Hypertension - high blood pressure; persistent BP measurements above the normal systolic (150 mm Hg) or diastolic (90 mm Hg) pressures

   D. Hypotension - low blood pressure; condition in which systolic BP is below 100 mm Hg and diastolic pressure is below 60 mm Hg

   E. Sphygmomanometer - instrument used to measure BP that consists of a cuff which is applied to the upper arm, and a measuring device

   F. Stethoscope - instrument used to listen to the sounds produced by the heart, lungs, and other body organs

   G. Systolic pressure - amount of force it takes to pump blood out of the heart into the arterial circulation

II. Blood Pressure Measurement

   A. Blood pressure measurement consists of measuring the systolic and diastolic pressures.

   B. Systole is the period of heart muscle contraction. Systolic pressure is the highest pressure and represents the amount of force it takes to pump blood out of the heart into the arteries. **(II-2)**

   C. Diastole is the period of heart muscle relaxation. Diastolic pressure is the lowest pressure and represents the amount of pressure in the arteries when the heart is at rest. **(II-3)**

   D. Factors that can increase blood pressure measurement

      1. Strong emotions

      2. Pain

3. Exercise

4. Some disease conditions

5. Some medications

E. Factors that can lower blood pressure measurement

1. Resting

2. Depression

3. Hemorrhage

4. Shock

5. Some medications

F. Normal range of blood pressure

1. Systolic - 100 to 150 mm Hg (II-4)

2. Diastolic - 60 to 90 mm Hg

G. Hypertension - persistent blood pressure measurements above normal systolic and diastolic pressures (II-5)

H. Hypotension - persistent blood pressure measurements below normal systolic and diastolic pressures

III. Equipment Used to Take a Blood Pressure Reading

A. Sphygmomanometer

1. Two types

a. Mercury manometer - has an upright gauge with a straight column of numbers (HO 1)

(1) The dial is marked off from zero to 300.

(2) It has measurements for each 10 points.

(3) Small lines between the large lines represent two point intervals. (II-6)

(4) View it with your eye at the same level as the top of the mercury column.

b. Aneroid manometer - has a round gauge with spring type arrow pointing to numbers (HO 2)

(1) The dial is marked off in unit measurements of 20 to 300; zero is at the center bottom of the gauge.

(2) Small lines between the large lines represent two point intervals.

(3) View it from straight on; do not view it from the side.

2. The mercury column and the needle on the aneroid manometer should be at the zero mark when not in use.

B. Cuff

1. A long, narrow piece of fabric that is wrapped around the arm and secured with Velcro. It has a rubber bag at one end that fills with air when bulb is pumped and applies pressure on the artery to stop the flow of blood.

2. Should be placed so that the center of the bag is over the brachial artery about one inch above the elbow. **(II-7)**

3. Cuff should be applied to the bare upper arm; do not apply over clothing. **(II-8)**

4. Cuff should be wrapped snugly but not tightly.

5. Tubing connects the cuff to the manometer and another tube connects the cuff to a small hand-held bulb. A valve on the bulb is turned clockwise to allow inflation of the cuff as the bulb is squeezed. By turning it counter clockwise, it allows deflation of the cuff and measurement of the blood pressure.

C. Stethoscope

1. An instrument that amplifies sound

2. Position the stethoscope for use with the earpieces facing forward. **(II-9)**

3. Use the flat diaphragm side of the stethoscope. Do not place your thumb on the diaphragm. Use fingers to hold the diaphragm in place.

4. Do not put too much pressure on the stethoscope because this will maintain pressure on the artery.

5. Always clean the earpieces with alcohol before and after taking the blood pressure.

IV. Measuring the Blood Pressure (HO 3)

A. Blood pressure should never be taken on an arm with an IV infusion or a cast.

B. If a client has had breast surgery, blood pressure is not taken on that side.

C. BP is normally measured in the brachial artery of one of the arms.

D. Room should be quiet so that the BP can be heard; talking and noises from T.V. and radio should be stopped.

E. The manometer must be clearly visible.

F. Arm should be supported at heart level.

G. Systolic reading is the first sound you hear as you let the air out; blood begins to flow through the artery with force as the heart contracts. **(II-10)**

H. Diastolic reading is the last sound you hear as you let the air out or the point that it changes to a soft, muffled thump; blood flows freely through the artery when the heart relaxes. **(II-11)**

I. If the sounds become muffled before stopping or remain muffled down to zero, record the diastolic at the point when you hear the change from clear to muffled, and when the sound ends. For example, 136/74/72.

V. Demonstrate Procedure for Measuring Blood Pressure. **(II-12 - 16)**

VI. Summary and Conclusion

A. Terms and definitions

B. Blood pressure measurement

C. Equipment used to take a blood pressure reading

D. Measuring the blood pressure

E. Review procedure for taking blood pressure.

The next lesson is on temperature, pulse, and respirations.

LESSON PLAN: 48

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

STEPS OF PROCEDURE FOR MEASURING BLOOD PRESSURE:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Position client seated/reclining with the entire lower arm on a flat surface, palm upward.
7. Expose the arm as much as possible. Squeeze the cuff to expel any remaining air and turn the valve clockwise on the bulb to close it.

   NOTE: Do not turn it too tightly or you will have trouble opening it.
8. Wrap cuff snugly around the upper arm at least one inch above the elbow.
9. Clean earpieces of stethoscope with alcohol sponge.
10. Locate the brachial pulse at the inner aspect of the elbow.
11. Place the earpieces of the stethoscope in your ears and place the diaphragm of the stethoscope over the brachial pulse.

    NOTE: Do not hold the bell in place with your thumb. Use fingers.
12. Hold the rubber bulb in the palm of the hand not holding the stethoscope.
13. Quickly inflate the cuff with air by pumping the bulb to 170-200 mm Hg.
14. Slightly loosen the valve counterclockwise. Deflate the cuff slowly and steadily. Listen carefully and watch the column of mercury or aneroid needle gauge for points where you hear the sound.

    NOTE: If you immediately hear pulse sounds, stop procedure. Deflate and remove the cuff. Wait 15 seconds, exercise arm, and repeat procedure. Inflate cuff to a higher calibration of 200-220 mm Hg. If pulse sounds at 220 mm Hg, report to charge nurse.

15. Note the systolic and diastolic readings.

16. Deflate the cuff completely when all sounds stop and remove it from the client's arm.

17. Remove stethoscope from your ears.

18. Do not reinflate the cuff during the reading. If you need to repeat procedure, deflate and remove the cuff. Wait 15 seconds, exercise arm, and repeat procedure.

19. Record blood pressure reading on paper.

20. Remove, clean, and store equipment.

21. Wash your hands.

22. Make the client comfortable; place call signal within reach.

23. Record observations and report anything unusual to the charge nurse.

LESSON PLAN: 48

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms presented in this lesson?
2. What happens to heart muscle during the systolic phase?
3. What happens to heart muscle during the diastolic phase?
4. What is the normal systolic and diastolic blood pressure range?
5. What is the difference between hypertension and hypotension?
6. Each small line on the manometer indicates how many points?
7. Over what artery do you usually place the cuff?
8. Is it appropriate to take a blood pressure with clothing covering the arm?
9. Which direction should the earpieces be facing when putting on a stethoscope?
10. At what point is the systolic reading noted?
11. At what point is the diastolic reading noted?
12. What position should the client be in when having his/her blood pressure taken?
13. Why should you clean the earpieces on the stethoscope?
14. How far up do you pump the cuff?
15. In what direction do you turn the valve to release air from the cuff?
16. What should you do if you hear pulse sounds immediately after opening the valve?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor shows students equipment used to take a blood pressure reading.
2. Have students complete HOs 1 and 2 for measuring blood pressure.
3. Show video.

4. Show students a diagram of the ear.

5. Instructor demonstrates the blood pressure procedure.

6. Students practice taking each other's blood pressure.

ANSWERS TO EVALUATION ITEMS:

1. f
2. d
3. g
4. c
5. a
6. b
7. e
8. d
9. d
10. b
11. b
12. a
13. c
14. b
15. c
16. forward
17. systolic
18. diastolic
19. a
20. b
21. Counterclockwise
22. c
23. c

LESSON PLAN: 48
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

Match the terms in Column I to the correct definitions in Column II by writing the letter in the blank.

Column I

___ 1. Sphygmomanometer
___ 2. Diastolic pressure
___ 3. Stethoscope
___ 4. Blood pressure
___ 5. Systolic pressure
___ 6. Hypertension
___ 7. Hypotension

Column II

a. Amount of force necessary to pump blood out of the heart into the arterial circulation
b. High blood pressure
c. Amount of force exerted against the walls of an artery by the blood
d. Pressure in the arteries when the heart is at rest
e. Low blood pressure
f. Used to measure BP; includes cuff and a measuring device
g. Used to listen to the sounds produced by the heart, lungs, and other body organs

8. The first sound you hear when taking a blood pressure is called: (Circle the letter of the best answer.)

   a. Blood pressure reading.
   b. Diastolic reading.
   c. Hypertension reading.
   d. Systolic reading.

9. During the systolic phase, the heart muscle is: (Circle the letter of the best answer.)

   a. Relaxed.
   b. Extended.
   c. Retracted.
   d. Contracted.

10. The normal systolic range of blood pressure is: (Circle the letter of the best answer.)

a. 150 to 200 mm Hg.
b. 100 to 150 mm Hg.
c. 60 to 90 mm Hg.
d. 160 to 170 mm Hg.

11. The normal diastolic range of blood pressure is: (Circle the letter of the best answer.)

a. 100 to 150 mm Hg.
b. 60 to 90 mm Hg.
c. 40 to 50 mm Hg.
d. 150 to 200 mm Hg.

12. Hypertension is defined as: (Circle the letter of the best answer.)

a. Above normal systolic and diastolic pressure.
b. Just normal diastolic and systolic pressure.
c. An elevated pulse rate and cardiac output.
d. Below normal systolic and diastolic pressure.

13. How many points does each small line on the manometer indicate? (Circle the letter of the best answer.)

a. 10 points
b. 1 point
c. 2 points
d. 5 points

14. When taking a blood pressure, the cuff is usually placed over the: (Circle the letter of the best answer.)

a. Carotid artery.
b. Brachial artery.
c. Radial artery.
d. Pulmonary artery.

15. The blood pressure cuff should be applied: (Circle the letter of the best answer.)

a. Loosely.
b. Over clothing.
c. On bare skin.
d. Very tight.

16. When positioning the earpieces of a stethoscope, they should be facing ____________________.

17. The first sound you hear as you let the air out of the blood pressure cuff is the ____________________ reading.

18. The last sound you hear as you let the air out of the blood pressure cuff is the ____________________ reading.

19. When taking a client's blood pressure, the arm should be positioned: (Circle the letter of the best answer.)

    a. With the lower arm on a flat surface, palm upward.
    b. With the lower arm suspended in air, bend of elbow exposed.
    c. With the upper arm above the level of the heart, rotated inward.
    d. With the lower arm hanging straight down, palm inward.

20. Which one of the following is correct procedure when measuring a blood pressure? (Circle the letter of the best answer.)

    a. There is no need to clean earpieces with an alcohol sponge
    b. Hold the bell of the stethoscope in place with your thumb
    c. Hold the bell of the stethoscope in place with your fingers
    d. Inflate the cuff with air by pumping the bulb to 120 mm Hg

21. When measuring a blood pressure the valve is loosened by turning it ____________________.

22. When measuring a blood pressure, what should you do if you hear pulse sounds immediately after opening the valve? (Circle the letter of the best answer.)

    a. Deflate the cuff and immediately retake the blood pressure
    b. Go get the charge nurse to take the blood pressure
    c. Stop the procedure, remove cuff, wait 15 seconds before retaking
    d. Stop the procedure, put machine away, and come back in one hour

23. Which one of the following pieces of equipment is not needed to take a blood pressure? (Circle the letter of the best answer.)

    a. Sphygmomanometer
    b. Stethoscope
    c. Otoscope
    d. Cuff

LESSON PLAN: 48

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

MEASURE BLOOD PRESSURE

EQUIPMENT:

1. Sphygmomanometer
2. Stethoscope
3. Alcohol sponges
4. Note pad and pencil

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Position client seated/reclining with the entire lower arm on a flat surface, palm upward.		
7. Expose the arm as much as possible. Squeeze the cuff to expel any remaining air and turn the valve clockwise on the bulb to close it. NOTE: Do not turn it too tightly or you will have trouble opening it.		
8. Wrap cuff snugly around the upper arm at least one inch above the elbow.		
9. Clean earpieces of stethoscope with alcohol sponge.		
10. Locate the brachial pulse at the inner aspect of the elbow.		
11. Place the earpieces of the stethoscope in your ears and place the diaphragm of the stethoscope over the brachial pulse. NOTE: Do not hold the bell in place with your thumb. Use fingers.		
12. Hold the rubber bulb in the palm of the hand not holding the stethoscope.		

13. Quickly inflate the cuff with air by pumping the bulb to 170-200 mm Hg.		
14. Slightly loosen the valve counterclockwise. Deflate cuff slowly and steadily. Listen carefully and watch the column of mercury or aneroid needle gauge for points where you hear the sound. NOTE: If you immediately hear pulse sounds, stop procedure. Deflate and remove the cuff. Wait 15 seconds, exercise arm, and repeat procedure. Inflate cuff to a higher calibration of 200-220 mm Hg. If pulse sounds at 220 mm Hg, report to charge nurse.		
15. Note the systolic and diastolic readings.		
16. Deflate the cuff completely when all sounds stop and remove it from the client's arm.		
17. Remove stethoscope from your ears.		
18. Do not reinflate the cuff during the reading. If you need to repeat procedure, deflate and remove the cuff. Wait 15 seconds, exercise arm, and repeat procedure.		
19. Record blood pressure reading on paper.		
20. Remove, clean, and store equipment.		
21. Wash your hands.		
22. Make the client comfortable; place call signal within reach.		
23. Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "MEASURE BLOOD PRESSURE" according to the steps outlined.

____
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

____
Date

READING A MERCURY SPHYGMOMANOMETER

Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line out from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.

BP 158/112

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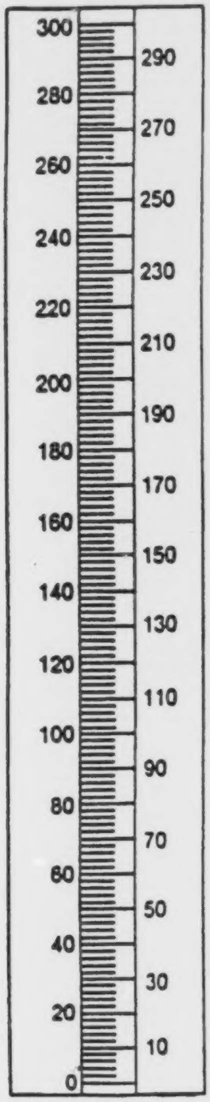
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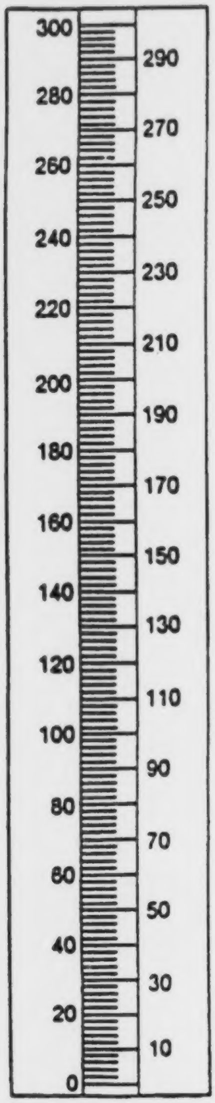
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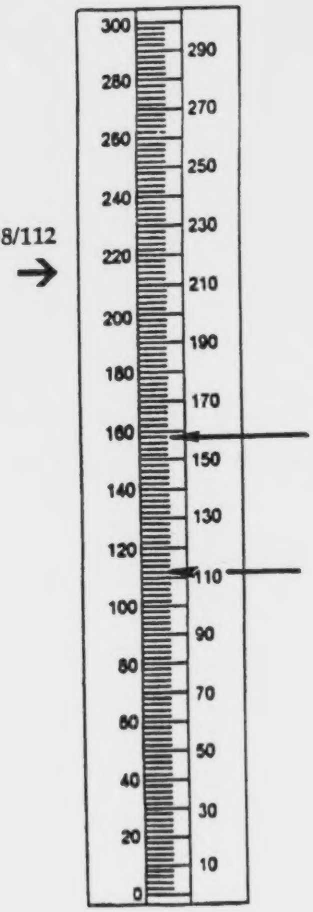
ANSWERS

BP 158/112



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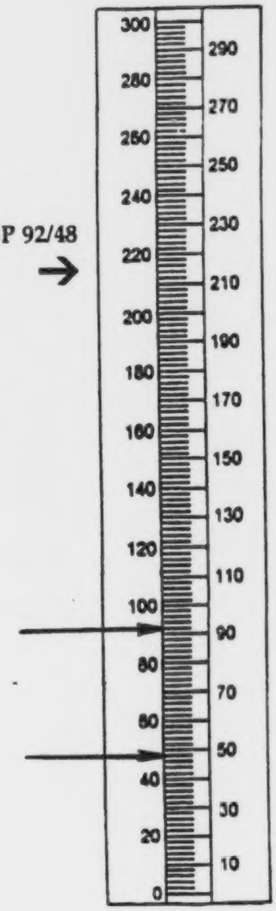

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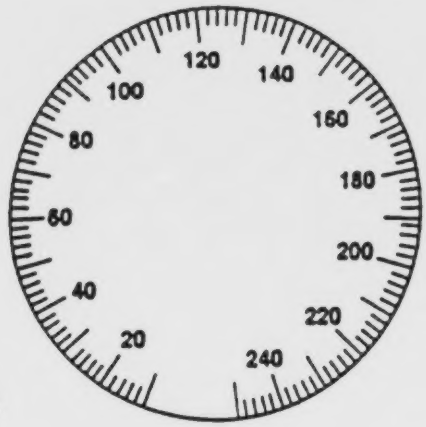
HO 2

READING AN ANEROID SPHYGMOMANOMETER

Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.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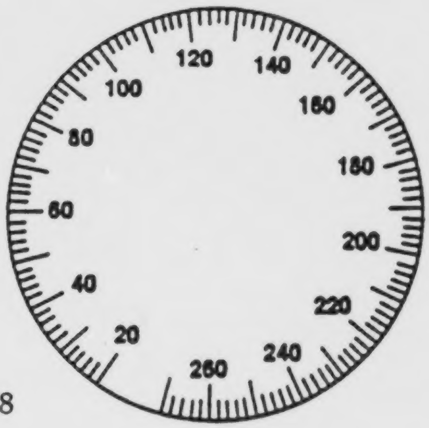
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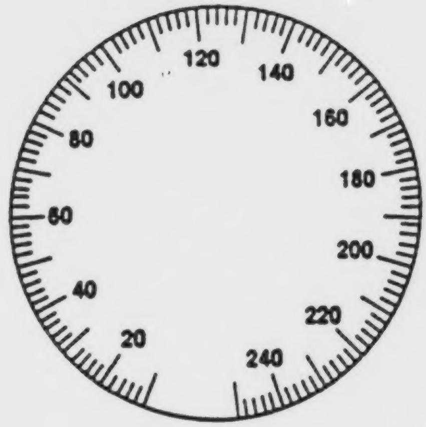
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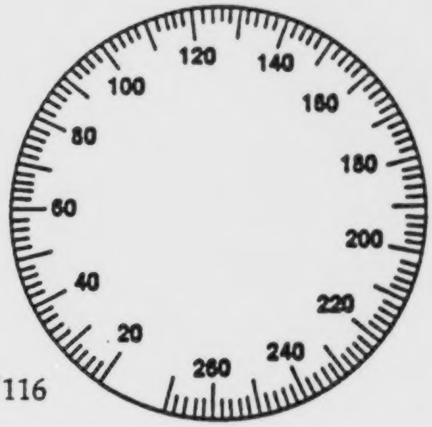
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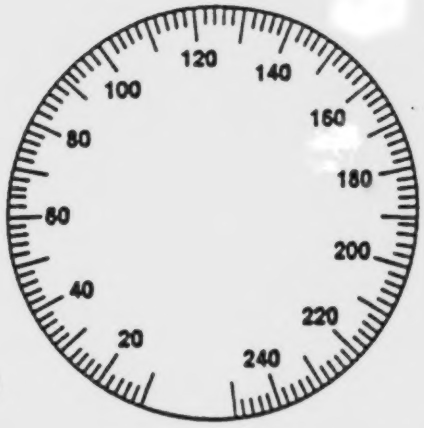
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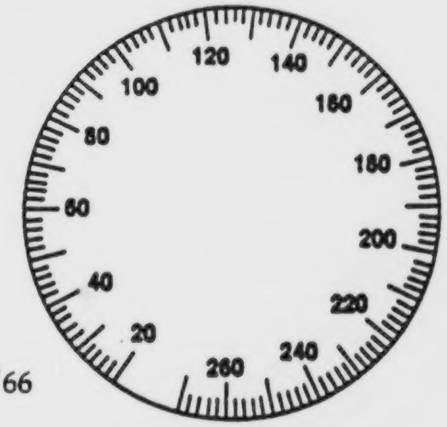
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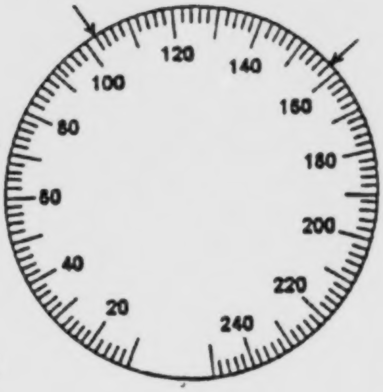
ANSWERS



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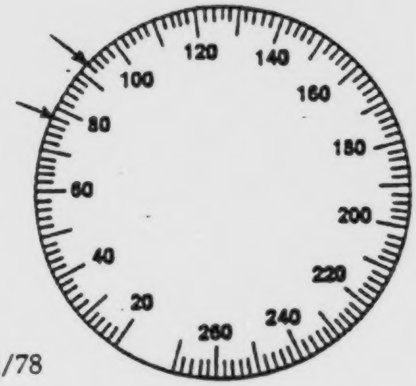

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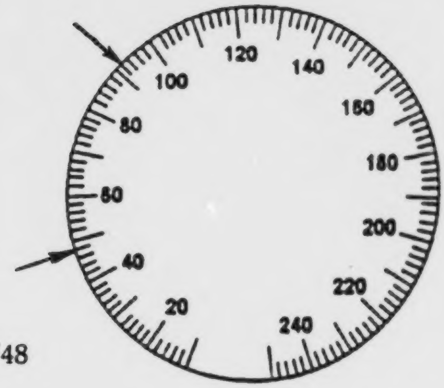

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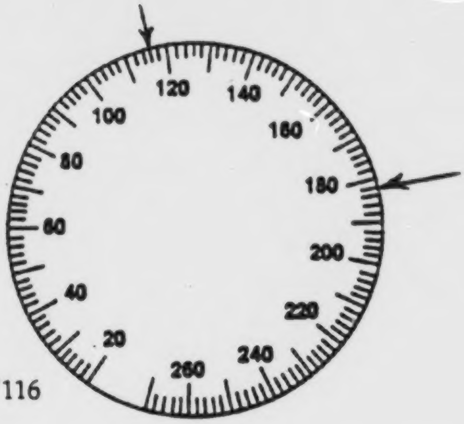

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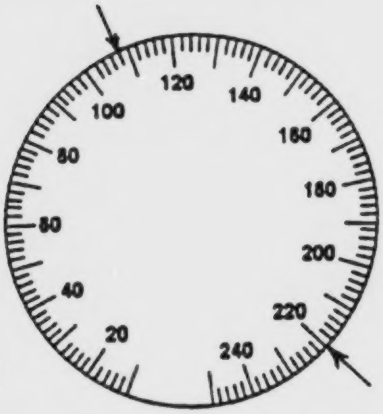

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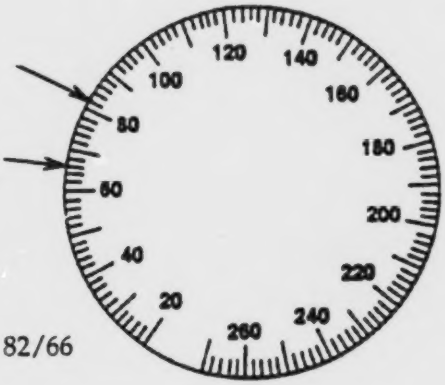

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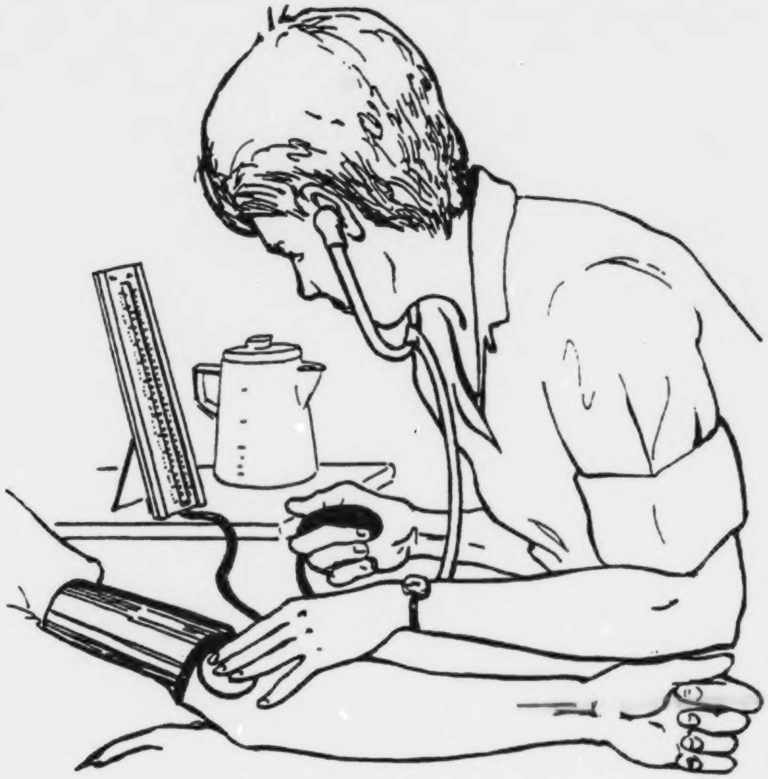
HO 3

PROPER POSITION FOR TAKING BLOOD PRESSURE



- The manometer must be clearly visable.
- Rest lower arm on chair, table or bed with palm upward.
- Hold the diaphragm of the stethoscope with your fingers, not with your thumb.

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

SCOPE OF UNIT:

This unit examines the structure and function of the cardiovascular system, including the heart and circulation, the lymphatics, blood vessels, and blood. Medical terms and definitions relating to the cardiovascular system are included. Vital signs are also included in this unit.

INFORMATION TOPIC: IX-49 AND DEMONSTRATION: IX-49

TEMPERATURE, PULSE, AND RESPIRATIONS (TPR)
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. Identify the normal range of body temperature for elderly persons.
3. Identify three types of thermometers.
4. Identify four ways to take a temperature.
5. List three conditions that would indicate not to take temperature by the oral route.
6. Describe the length of time to take a temperature for each route.
7. Identify the normal pulse range for the elderly adult.
8. List five locations at which a pulse can be checked.
9. Identify the normal range for respirations.
10. List three signs of normal respirations.

Demonstration

11. Take oral temperature according to the steps of procedure.
12. Take rectal temperature according to the steps of procedure.

13. Take axillary temperature according to the steps of procedure.
14. Count radial pulse according to the steps of procedure.
15. Count respirations according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Common Thermometers (Fahrenheit)
2. HO 2: Sites for Taking a Pulse
3. HO 3: The Circulatory System Primary Pulse Points
4. HO 4: Reading a Thermometer
5. Measuring Assistant Techniques; Measuring Temperature, video #2, available from the Missouri Vocational Resource Center, 16 min.
6. Glass oral thermometer and holder
7. Glass rectal thermometer and holder
8. Electronic thermometer with oral and rectal probes and disposable probe covers
9. Tympanic thermometer
10. Tissues
11. Plastic thermometer cover (if available)
12. Paper and pen
13. Water-soluble lubricant
14. Disposable gloves, if available
15. Towel
16. Chase doll
17. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 49 (Student Reference page 783) prior to class and be prepared to discuss the information presented and return the demonstrations on taking TPR according to the steps of procedure. Have students do thermometer reading exercise HO 4.

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INTRODUCTION:

Taking temperature, pulse, and respirations are part of checking vital signs. This is a procedure that you must completely understand how to perform so that you will feel confident and be accurate. Some medications and treatments may be administered or discontinued depending upon what the vital signs are. If you are ever in doubt, ask the charge nurse to recheck your reading. The following lesson plan will give you some of the answers as to why these are considered the signs of life and will then inform you of the actual steps of the procedures.

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

  A. Axilla - armpit

  B. Body temperature - the amount of heat in the body that is a balance between the amount of heat produced and the amount lost by the body

  C. Cheyne-Stokes - a pattern of breathing in which respirations gradually increase in rate and depth and then become shallow and slow; breathing may stop for 10 to 20 seconds

  D. Pulse - the beat of the heart felt at an artery as a wave of blood passes through the artery

  E. Pulse rate - the number of heartbeats or pulses felt in one minute

  F. Respirations - act of breathing in and out of the lungs (inhalation/exhalation)

  G. Vital signs - temperature, pulse, respirations, and blood pressure

  H. Bradycardia - abnormally slow heart beat; below 60 beats per minute

  I. Tachycardia - abnormally fast heart beat

II. Body Temperature

  A. A balance between heat gained and heat lost

  B. Normal oral temperature range for a resting younger adult is 97.0°F to 99.0°F.

  C. Average oral temperature of elderly persons is 96.8°F. Normal body temperature in the aged may be as low as 95.0°. A temperature of 98.0°F would be a severe elevation for that particular client, but it could be missed because it is a low normal reading for younger adults. Such a missed diagnosis can delay correction of the problem. All nursing staff should understand that a lower body temperature in an aged individual can be the normal value for that person. **(II-2)**

  D. Heat is conserved by the body as follows:

    1. Reduction of perspiration

970

2. Vasoconstriction - decrease in flow of blood to skin

3. Shivering - increased muscle activity to produce heat

E. Heat is lost by the body as follows:

1. Vasodilation - increased blood flow to skin, flushed appearance

2. Through the lungs by breathing - increased respirations rate

3. Elimination of urine, stool, and perspiration

F. Fever - an elevation of the body temperature above the usual normal range

G. Measures to raise body temperatures

1. Increase the temperature of the room.

2. Add coverings to the body.

3. Provide hot liquids to drink.

4. Give warm bath or soaks.

H. Measures to lower body temperature

1. Decrease the temperature of the room.

2. Remove coverings from the body.

3. Offer cool liquids to drink.

4. Provide cool bath or sponging.

5. Direct fan toward the body.

I. An axillary reading is approximately one degree lower than an oral temperature reading. A rectal reading is approximately one degree higher than an oral temperature reading.

III. Measuring Body Temperature

A. Types of thermometers: (HO 1) **(II-3)**

1. Glass with long, narrow tip

a. Used for oral or axillary temperatures

b. Color-coded blue

   c. Never used to take rectal temperature because it could injure tissues in the rectum

2. Glass with rounded, stubby tip

   a. Used for taking rectal temperature

   b. Color-coded red

3. Electronic

   a. Portable and battery operated

   b. Measures temperature within 2 to 60 seconds, depending upon model.

   c. Displays temperatures digitally on front of thermometer unit.

   d. Oral and rectal probes are supplied.

   e. Disposable cover or sheath is used to cover the probe.

   f. Use the cover only once and then discard. (II-4)

4. Tympanic or aural ear method

   a. This is the newest method of taking a temperature.

   b. The aural thermometer measures the temperature from blood vessels in the tympanic membrane in the ear.

   c. The instrument has a built-in converter that provides the equivalent temperature in rectal or oral values.

   d. There is less chance of spreading infection with this method because the ear is lined with skin instead of mucous membrane.

   e. It must be positioned properly to obtain an accurate reading

B. Reading a glass Fahrenheit scale thermometer

1. The thermometer has a bulb end and a stem end.

2. Mercury collects in the bulb end; when warmed, it rises up a hollow tube in the stem of the thermometer. (II-5)

3. The temperature is recorded at the point the mercury stops.

4. Hold the thermometer at the stem end; NEVER AT THE BULB END.

5. Stand with your back to the light.

6. Hold thermometer at eye level and rotate it slightly back and forth until the column of mercury is visible.

7. Each long line represents one degree - 94°, 95°, etc.

8. Odd-numbered degrees (95°, 97°, etc.) are not written on the thermometer.

9. Each short mark is two-tenths of a degree; they go from 2/10 to 8/10 between the larger numbers.

10. Two-tenths means the same whether it is written as 2/10 or .2.

11. The small arrow at 98.6°F indicates the normal oral temperature of a young adult **(II-6)**

IV. Ways to Take a Temperature

A. Oral

1. For the elderly, the oral method is the most common and most accurate for assessment purposes (if your client is able to hold a thermometer in place under the tongue).

2. Time required for an accurate reading is five to eight minutes. **(II-7)**

3. DO NOT TAKE AN ORAL TEMPERATURE IF THE CLIENT:

   a. Has been smoking, chewing gum, or consumed a hot/cold beverage; wait 30 minutes before taking **(II-8)**

   b. Is unconscious **(II-9)**

   c. Has had surgery or an injury to the face, neck, nose, or mouth

   d. Is receiving oxygen

   e. Breathes through the mouth instead of the nose

   f. Is delirious, restless, confused, or disoriented

   g. Is paralyzed on one side of the body due to a stroke

   h. Is an infant or child under five years of age

4. Instruct client not to talk during procedure.

B. Rectal

1. Reduced blood flow to the lower bowel and the possible presence of feces may cause inaccurate rectal temperature readings. This route is not routinely used except when oral temperature cannot be taken for reason(s) listed above.

2. Time required for an accurate reading is three to four minutes. **(II-10)**

3. Client should not be left alone during procedure; thermometer should always be held while temperature is being taken with client on his/her side while the health care assistant holds the top hip in place to prevent client from rolling back.

4. Lubrication of thermometer is important so that it can be inserted easily and not cause tissue injury. **(II-11)**

5. DO NOT TAKE A RECTAL TEMPERATURE IF THE CLIENT:

   a. Has diarrhea

   b. Has a rectal disorder, injury, or recent rectal surgery

6. In charting, indicate rectal method by writing "R" after the numbers; for example 99 R. **(II-12)**

C. Axillary

1. Used when the temperature cannot be taken orally or rectally.

2. Time required for an accurate reading is 10 to 12 minutes.

3. This method should not be used immediately after bathing; the axilla should be dry. Thermometer should be held in place to maintain proper position. Hold the upper arm against the body.

4. In charting, indicate axillary method by writing "A" after the numbers; for example 96.8 A.

D. Tympanic or aural ear method

1. Newest method - facilities may not have this type of thermometer available for daily use.

2. An accurate reading can be obtained in less than one minute if the probe is properly placed.

V. Pulse

A. Pulse is the beat of the heart felt at an artery as a wave of blood passes through the artery; a pulse can be felt every time the heart beats. The rate varies with different age groups. (II-13)

   1. Newborn - 70-170 beats per minute

   2. Infant - 80-130 beats per minute

   3. Toddler - 80-120 beats per minute

   4. School age - 70-110 beats per minute

   5. Adult - 60-100 beats per minute

   6. Elderly adult - 50-100 beats per minute.

B. When taking the pulse, count the rate for one full minute.

C. Factors that elevate the pulse

   1. Exercise

   2. Strong emotion (anger, fear, etc.)

   3. Fever

   4. Pain

   5. Shock

D. Factors that lower the pulse

   1. Resting

   2. Depression

   3. Certain drugs (such as digitalis)

E. When taking the pulse, note the rhythm of the pulse.

   1. Regular rhythm - pulse is felt in a pattern with the same time interval occurring between beats

   2. Irregular rhythm - noted when the beats are unevenly spaced or beats are skipped

F. When taking the pulse, note the force of the pulse.

1. A forceful pulse is easy to feel and is described as being strong, full, or bounding.

2. A weak pulse is hard to feel and is described as weak or thready.

VI. Sites For Taking Pulse (HO 2) **(II-14)**

A. Radial pulse

1. Most common and convenient site.

2. Pulse is located on the side of the wrist near the client's thumb; it can be felt by placing the first three fingers of one hand against the radial artery.

3. Do not take the pulse with your thumb because it has a pulse of its own, which could be mistaken for the client's pulse.

4. It is routine to take a client's pulse and respirations while taking the temperature.

5. Do not record the pulse immediately; keep the number in mind and continue holding the client's hand until you have counted the respirations.

B. Carotid pulse

1. Located on the side of the neck

2. Check one side at a time; never push on both carotid arteries at the same time--this will cause fainting.

3. Not a preferred method for elderly

C. Brachial pulse - located at the bend of the elbow

D. Femoral pulse - located at the groin area

E. Apical pulse

1. Located on the left side of the chest slightly below the nipple; must use a stethoscope **(II-15)**

2. The heartbeat normally sounds like a "lub-dub." Each "lub-dub" is counted as one beat.

3. Use if radial pulse is difficult to take

VII. Respirations

A. One respiration includes breathing in and breathing out; the chest rises upon inhalation and falls during exhalation.

B. Respiratory rate is the number of respirations in one minute; the normal range for an adult is between 14 and 20. Report to the charge nurse if respirations do not fall within this range. **(II-16)**

C. The respiratory rate is affected by the same factors as those that can elevate/lower the pulse.

VIII. Measuring Respirations

A. Normal respirations are: **(II-17)**

1. Quiet

2. Effortless

3. Regular

4. Both sides of chest rise and fall equally

B. To count respirations, you must be able to see the chest rise and fall. The client must not be aware that you are counting respirations because he/she may subconsciously or intentionally alter the pattern.

C. Count the respirations right after counting the pulse; the fingers should be left in place over the pulse site, thus the client will assume that the pulse is still being counted.

IX. Demonstrate Procedures for Taking TPR. **(II-20 - 28)**

X. Summary and Conclusion

A. Terms and definitions

B. Body temperature

C. Measuring body temperature

D. Ways to make a temperature

E. Pulse

F. Sites for taking a pulse

G. Respirations

H. Measuring respirations

I. Review procedures for taking TPR.

Taking the TPR contributes to the overall evaluation of the client's condition. It should be done with great accuracy and whenever there is an indication of change of condition. Most long-term care facilities check the client's TPR at least once a month. In acute care, the client's vital signs are taken more often as ordered by the physician, sometimes as often as every 15 minutes. The next unit will be on the respiratory system.

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

STEPS OF PROCEDURE FOR TAKING ORAL TEMPERATURE:

1. Wash your hands. Put on gloves.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Client should be in sitting/lying down position.
7. Using a glass bulb thermometer
    a. Rinse thermometer with cool water if it has been soaked in disinfectant solution.
    b. Check thermometer for breaks or chips.
    c. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.
    d. Ask client to open mouth and raise tongue. Place the thermometer bulb under client's tongue toward side of mouth.
    e. Instruct the client to hold the thermometer in place by closing his/her lips around the thermometer, while holding bulb under tongue. Leave in place for at least five minutes.
    f. Grasp the stem end of the thermometer and remove it from the client's mouth. Wipe thermometer from the stem toward the bulb end with a tissue.
    g. Read the thermometer.
    h. Record the temperature reading on the paper.
    i. Shake down the thermometer.

    Using an electronic thermometer
    a. Make sure oral probe is plugged into the thermometer.
    b. Remove the probe from the unit and insert it into a probe cover.

    c. Ask client to open the mouth and raise the tongue; place covered probe at the base of the tongue on either side.

    d. Ask the client to lower the tongue and close the mouth.

    e. The health care assistant should hold the probe in the client's mouth until the tone is heard or when there is a flashing or steady light.

    f. Read the temperature reading on the digital display.

    g. Remove the covered probe from the client's mouth and discard the probe cover by pressing the eject button.

    h. Record the temperature reading on paper.

    i. Return the probe to the holder.

8. Remove, clean, and store equipment.

9. Remove gloves and dispose in appropriate container. Wash hands.

10. Make the client comfortable; place call signal within reach.

11. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR TAKING RECTAL TEMPERATURE:

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Instruct/assist client to lie on his/her side with upper leg flexed.

7. Rinse thermometer with cool water if it has been soaked in disinfectant solution.

8. Check thermometer for breaks or chips.

9. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.

10. Put a small amount of lubricant on a tissue and lubricate the bulb end of the thermometer.

11. Raise the upper buttock to expose the anus; insert bulb end of the thermometer one inch into the rectum. Cover client.
12. Hold the thermometer in place for three to four minutes while holding top hip of client to prevent rolling back.
13. Remove the thermometer. Wipe it clean with tissues from the stem toward the bulb.
14. Place the thermometer on clean toilet tissue, wipe the anal area to remove excess lubricant.
15. Cover the client.
16. Read the thermometer and record temperature reading on paper.
17. Shake down the thermometer.
18. Remove, clean, and store equipment.
19. Remove gloves and dispose in appropriate container. Wash hands.
20. Make the client comfortable; place call signal within reach.
21. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR TAKING AXILLARY TEMPERATURE:

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Rinse thermometer with cool water if it has been soaked in disinfectant solution.
7. Check thermometer for breaks or chips.
8. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.
9. Instruct/assist client to assume sitting or supine position.
10. Help the client remove an arm from the sleeve of the gown without exposing the client.
11. Dry axilla of excessive perspiration with a towel.

12. Place bulb end of thermometer in the center of axilla.

13. Bring the arm across the chest and hold in place to snugly hold the thermometer in place for 10 to 12 minutes.

14. Remove thermometer. Read and record temperature reading.

15. Shake down the thermometer.

16. Remove, clean, and store equipment.

17. Wash your hands.

18. Make the client comfortable; place call signal within reach.

19. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR COUNTING RADIAL PULSE:

1. Wash your hands.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. Client should be in sitting/supine position.

7. Place fingertips over radial artery and locate pulse.

8. Note if the pulse is strong or weak and regular or irregular.

9. Count the pulse for one full minute. Recount if unsure of reading.

10. Note any abnormal characteristics of the pulse.

11. Record pulse reading on paper.

12. Wash your hands.

13. Make the client comfortable; place call signal within reach.

14. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR COUNTING RESPIRATIONS:

1. Wash your hands.

2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Client should be in sitting/supine position.
7. Rest client's arm across his/her chest with your fingers on radial pulse for ease in observing rise and fall of chest cavity during respirations.
8. Begin counting respirations when you see the chest rise; count respirations for one full minute. Recount if unsure.
9. Note any abnormal characteristics of respirations.
10. Record number of respirations on paper.
11. Wash your hands.
12. Make the client comfortable; place call signal within reach.
13. Record observations and report anything unusual to the charge nurse.

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms presented in this lesson?
2. What is normal oral temperature for an elderly person? For a young adult?
3. What are three types of thermometers?
4. Are the probe covers used with an electronic thermometer reusable?
5. What is the substance contained in a glass thermometer?
6. What does the small arrow indicate on a glass thermometer?
7. How long do you have an oral thermometer in the client's mouth?
8. How long should you wait if a client has been chewing gum before checking his/her temperature?
9. What three conditions of the elderly would indicate you should not take a temperature by the oral route?
10. How many minutes are required for an accurate rectal reading?
11. What is the normal rectal temperature for an elderly client?
12. What should you remember to do before inserting a thermometer into the rectum?
13. When recording a rectal temperature, what should you do?
14. What are the five sites where a pulse is taken?
15. When checking an apical pulse, what piece of equipment do you need?
16. What is the normal respiration rate?
17. How would you describe normal respirations?
18. To what degree should the glass thermometer be shaken down?
19. What position should the client be in when taking an oral temperature?
20. Where are the fingers placed when taking the pulse?

21. What should you note about the pulse when counting it?

22. In what direction is a glass thermometer wiped?

23. How do you know when the temperature is to be read when using an electronic thermometer?

24. When would you count the pulse and respirations when checking temperature using an electronic thermometer?

25. What position should the client be in when taking a rectal temperature?

26. How far should the thermometer be inserted into the rectum?

27. When should you count the pulse and respirations when taking a rectal temperature?

28. What position should the client be in when taking an axillary temperature?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show students different types of thermometers. If the aural thermometer is not available, show students a picture of it such as the one on page 231 of Nursing Assistant, A Nursing Process Approach by Barbara Hegner and Ester Caldwell, 6th ed., 1992, Delmar Publishers.

2. Have students locate pulse at different sites.

3. Have students complete HO 4: Reading a Thermometer. (Answers are on the back side of the handout.

4. Instructor demonstrates taking temperature, pulse, and respirations procedures.

5. Students practice taking each other's temperature, pulse, and respirations.

6. Students practice inserting a rectal thermometer using Chase doll.

ANSWERS TO EVALUATION ITEMS:

1. f
2. c
3. d
4. a
5. e
6. b
7. g
8. c
9. c

10. reusable
11. Mercury
12. d
13. a
14. b
15. d
16. c
17. a
18. a
19. d
20. lubricated
21. c
22. c
23. a
24. d
25. e
26. b
27. d
28. c
29. b
30. a
31. b
32. a
33. d
34. rhythm
35. d
36. b
37. d

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX : THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

Match the terms in Column I to the correct definitions in Column II by writing the letter in the blank.

Column I

___ 1. Pulse

___ 2. Vital signs

___ 3. Cheyne-stokes

___ 4. Respirations

___ 5. Axilla

___ 6. Body temperature

___ 7. Pulse rate

Column II

a. Act of breathing in and out of the lungs

b. Balance of amount of heat produced and amount of heat lost by the body

c. TPR and BP

d. A pattern of breathing in which respirations are uneven and may stop for brief periods

e. Armpit

f. The beat of the heart felt at an artery as a wave of blood passes through it

g. The number of heartbeats felt in one minute

8. The normal average oral temperature for an elderly person is: (Circle the letter of the best answer.)

   a. 98.6°F.
   b. 97°F.
   c. 96.8°F.
   d. 99.2°F.

9. Which of the following is not a type of thermometer used? (Circle the letter of the best answer.)

   a. Electronic
   b. Glass with long, narrow tip
   c. Stethoscope
   d. Glass with rounded, stubby tip

10. When using an electronic thermometer, the probe cover is not ____________________.

11. The substance contained in a glass thermometer is ____________________.

12. The small arrow on a glass Fahrenheit thermometer indicates: (Circle the letter of the best answer.)

    a. 99.6°F.
    b. 96.8°F.
    c. 97.6°F.
    d. 98.6°F.

13. Each short mark on a Fahrenheit thermometer is: (Circle the letter of the best answer.)

    a. 2/10 of a degree.
    b. 1/10 of a degree.
    c. 2 degrees.
    d. 1 degree.

14. The time required for an accurate reading of the oral temperature is: (Circle the letter of the best answer.)

    a. 3 to 4 minutes.
    b. 5 to 8 minutes.
    c. 10 to 12 minutes.
    d. Less than one minute.

15. If your assigned client has been smoking, chewing gum, or drinking, you should wait how many minutes before taking his/her oral temperature? (Circle the letter of the best answer.)

    a. 10 to 12 minutes
    b. 5 to 8 minutes
    c. 15 minutes
    d. 30 minutes

16. Which of the following conditions of the elderly would indicate to you that you should not take a temperature by the oral route? (Circle the letter of the best answer.)

    a. Snores when sleeping
    b. Is very talkative
    c. Is unconscious
    d. Chews gum

17. How long should the rectal thermometer remain in the anus to get an accurate reading? (Circle the letter of the best answer.)

    a. 3 to 4 minutes
    b. 5 to 8 minutes
    c. 10 to 12 minutes
    d. Less than one minute

18. The average normal rectal temperature for an elderly adult is: (Circle the letter of the best answer.)

    a. 97.8°F.
    b. 98.6°F.
    c. 98.8°F.
    d. 99.2°F.

19. Which one of the following is the correct method for charting a rectal temperature? (Circle the letter of the best answer.)

    a. 96.6 O
    b. 96.6 A
    c. 96.6
    d. 96.6 R

20. Before inserting a rectal thermometer, the thermometer should be ____________________.

21. The average pulse range of an elderly adult is between: (Circle the letter of the best answer.)

    a. 100 and 120 beats per minute
    b. 30 and 40 beats per minute
    c. 50 and 100 beats per minute
    d. 90 and 110 beats per minute

Match the pulse site in Column I with the correct location in Column II.

	Column I		Column II
___ 22.	Radial	a.	On the left side of the chest, slightly below the nipple
___ 23.	Apical	b.	At the groin area
___ 24.	Carotid	c.	On the side of the wrist, near the thumb
___ 25.	Brachial	d.	On the side of the neck
___ 26.	Femoral	e.	At the bend of the elbow

27. When taking an apical pulse you should use a (an): (Circle the letter of the best answer.)

    a. Otoscope.
    b. Proctoscope.
    c. Cystoscope.
    d. Stethoscope.

28. The normal respiratory rate for an adult is: (Circle the letter of the best answer.)

a. 12 and below.
b. 30 to 40.
c. 14 to 20.
d. 10 to 12.

29. Which one of the following describes normal respirations? (Circle the letter of the best answer.)

a. Rapid and noisy
b. Effortless and regular
c. Shallow
d. Rise and fall of chest alternates

30. When using a glass bulb thermometer, you should shake it down to: (Circle the letter of the best answer.)

a. 94°F or below.
b. 98.6°F.
c. 96.2°F.
d. 97°F.

31. Which one of the following statements is true about the procedure for taking a blood pressure? (Circle the letter of the best answer.)

a. It is okay to take a blood pressure in the arm which has an IV.
b. If a client has had breast surgery the blood pressure should be taken on the opposite arm.
c. The blood pressure cuff can be applied over clothing.
d. The blood pressure cuff should be applied eight minutes before taking the reading.

32. Which of the following is not a way to take a temperature? (Circle the letter of the best answer.)

a. Under the knee
b. Axilla
c. Rectal
d. Oral

33. Which of the following are signs of normal respirations? (Circle the letter of the best answer.)

a. Effortless
b. Regular
c. Quiet
d. All of the above

34. When taking a pulse, you should note the ________________ of the pulse.

35. A forceful pulse is described as being: (Circle the letter of the best answer.)

a. Strong.
b. Full.
c. Bounding.
d. All of the above.

36. A glass thermometer is wiped: (Circle the letter of the best answer.)

a. From the bottom upward.
b. From the stem toward the bulb end.
c. From the bulb end toward the stem end.
d. However you want.

37. A rectal thermometer is inserted how many inches into the rectum? (Circle the letter of the best answer.)

a. 5 inches
b. 3 inches
c. 2 inches
d. 1 inches

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

TAKE ORAL TEMPERATURE

EQUIPMENT:

1. Glass oral thermometer and holder
2. Electronic thermometer
3. Tissues
4. Plastic thermometer cover (if available)
5. Disposable probe cover
6. Paper and pen
7. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Client should be in sitting/lying down position.		
7. Using a glass bulb thermometer a. Rinse thermometer with cool water if it has been soaked in disinfectant solution.		
b. Check thermometer for breaks or chips.		
c. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.		
d. Ask client to open mouth and raise tongue. Place the thermometer bulb under the client's tongue toward side of mouth.		
e. Instruct the client to hold the thermometer in place by closing his/her lips around the thermometer, while holding bulb under tongue. Leave in place for at least five minutes.		

f.	Grasp the stem end of the thermometer and remove it from the client's mouth and wipe it from the stem toward the bulb end with a tissue.		
g.	Read the thermometer.		
h.	Record the temperature reading on the paper.		
i.	Shake down the thermometer.		
a.	Using an electronic thermometer Make sure oral probe is plugged into the thermometer.		
b.	Remove the probe from the unit and insert it into a probe cover.		
c.	Ask client to open the mouth and raise the tongue; place covered probe at the base of the tongue on either side.		
d.	Ask the client to lower the tongue and close the mouth.		
e.	The health care assistant should hold the probe in the client's mouth until the tone is heard or when there is a flashing or steady light.		
f.	Read the temperature reading on the digital display.		
g.	Remove the covered probe from the client's mouth and discard the probe cover by pressing the eject button.		
h.	Record the temperature reading on paper.		
i.	Return the probe to the holder.		
8.	Remove, clean, and store equipment.		
9.	Remove gloves and dispose in appropriate container. Wash hands.		
10.	Make the client comfortable; place call signal within reach.		
11.	Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "TAKE ORAL TEMPERATURE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

TAKE RECTAL TEMPERATURE

EQUIPMENT:

1. Glass rectal thermometer and holder
2. Tissues
3. Plastic thermometer cover (if available)
4. Paper and pen
5. Water-soluble lubricant
6. Gloves
7. Chase doll

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
6. Instruct/assist client to lie on his/her side with upper leg flexed.		
7. Rinse thermometer with cool water if it has been soaked in disinfectant solution.		
8. Check thermometer for breaks or chips.		
9. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.		
10. Put a small amount of lubricant on a tissue and lubricate the bulb end of the thermometer.		
11. Raise the upper buttock to expose the anus; insert bulb end of thermometer one inch into the rectum. Cover client.		
12. Hold the thermometer in place for three to four minutes while holding top hip of client to prevent rolling back.		
13. Remove the thermometer. Wipe it clean with tissue from the stem toward the bulb.		

14.	Place the thermometer on clean toilet tissue, wipe the anal area to remove excess lubricant.		
15.	Cover the client.		
16.	Read the thermometer and record temperature reading on paper.		
17.	Shake down the thermometer.		
18.	Remove, clean, and store equipment.		
19.	Remove gloves and dispose in appropriate container. Wash hands.		
20.	Make the client comfortable; place call signal within reach.		
21.	Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "TAKE RECTAL TEMPERATURE" according to the steps outlined.

____
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

____
Date

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT: ______________

TAKE AXILLARY TEMPERATURE

EQUIPMENT:

1. Glass oral thermometer and holder
2. Plastic thermometer cover (if available)
3. Paper and pen
4. Towel

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
6. Rinse thermometer with cool water if it has been soaked in disinfectant solution.		
7. Check thermometer for breaks or chips.		
8. Shake down thermometer to 94°F or below; firmly grasp at the stem end and snap your wrist several times.		
9. Instruct/assist client to assume sitting or supine position.		
10. Help the client remove an arm from the sleeve of the gown without exposing client.		
11. Dry axilla of excessive perspiration with a towel.		
12. Place bulb end of thermometer in the center of axilla.		
13. Bring the arm across the chest and hold in place to snugly hold the thermometer in place for 10 to 12 minutes.		
14. Remove thermometer. Read and record temperature reading.		
15. Shake down the thermometer.		
16. Remove, clean, and store equipment.		

17.	Wash your hands.		
18.	Make the client comfortable; place call signal within reach.		
19.	Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "TAKE AXILLARY TEMPERATURE" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX: THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

COUNT RADIAL PULSE

EQUIPMENT:

1. Watch with second hand
2. Pencil and paper

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Client should be in sitting/supine position.		
7. Place fingertips over radial artery and locate pulse.		
8. Note if the pulse is strong or weak and regular or irregular.		
9. Count the pulse for one full minute. Recount if unsure of reading.		
10. Note any abnormal characteristics of the pulse.		
11. Record pulse reading on paper.		
12. Wash your hands.		
13. Make the client comfortable; place call signal within reach.		
14. Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "COUNT RADIAL PULSE" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 49

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT IX : THE CARDIOVASCULAR SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

COUNT RESPIRATIONS

EQUIPMENT:

1. Watch with second hand
2. Pencil and paper

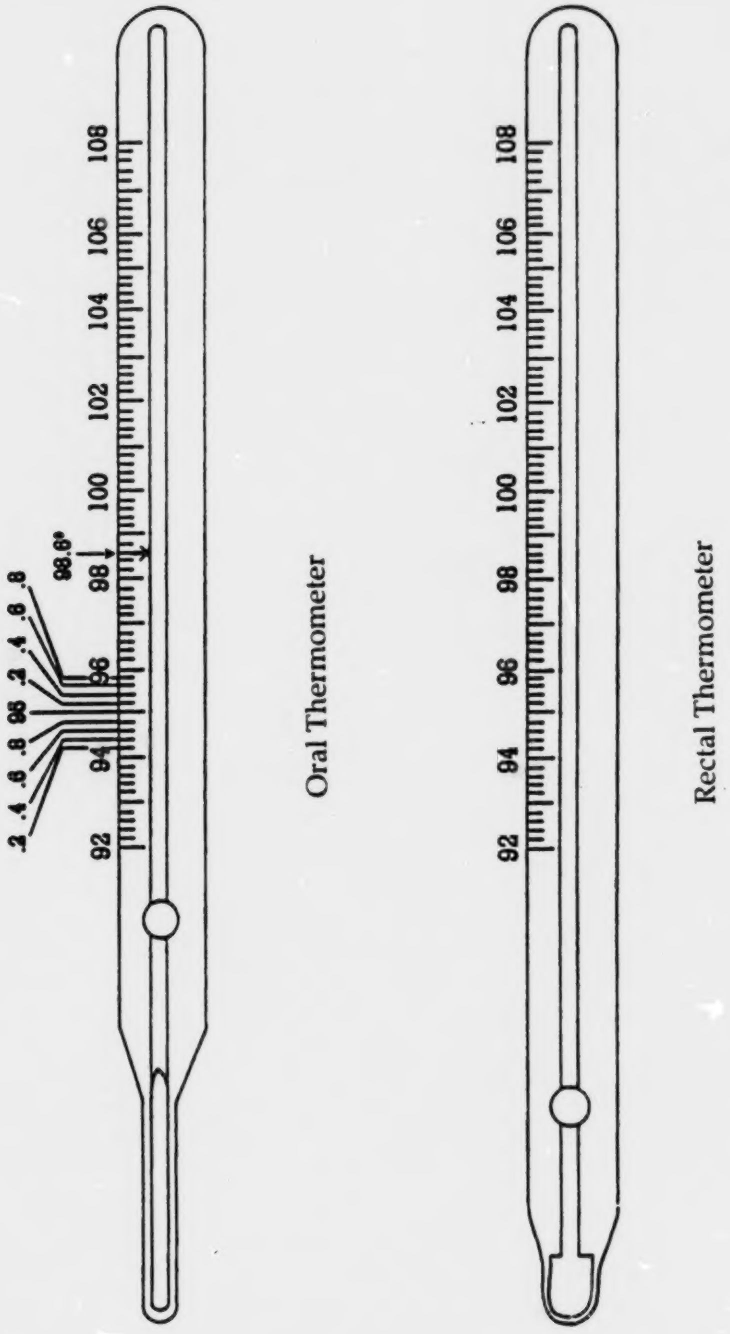
CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Client should be in sitting/supine position.		
7. Rest client's arm across his/her chest with your fingers on radial pulse for ease in observing rise and fall of chest cavity during respirations.		
8. Begin counting respirations when you see the chest rise; count respirations for one full minute. Recount if unsure.		
9. Note any abnormal characteristics of respirations.		
10. Record number of respirations on paper.		
11. Wash your hands.		
12. Make the client comfortable; place call signal within reach.		
13. Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "COUNT RESPIRATIONS" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

COMMON THERMOMETERS (Fahrenheit)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98.6°
Oral Thermometer
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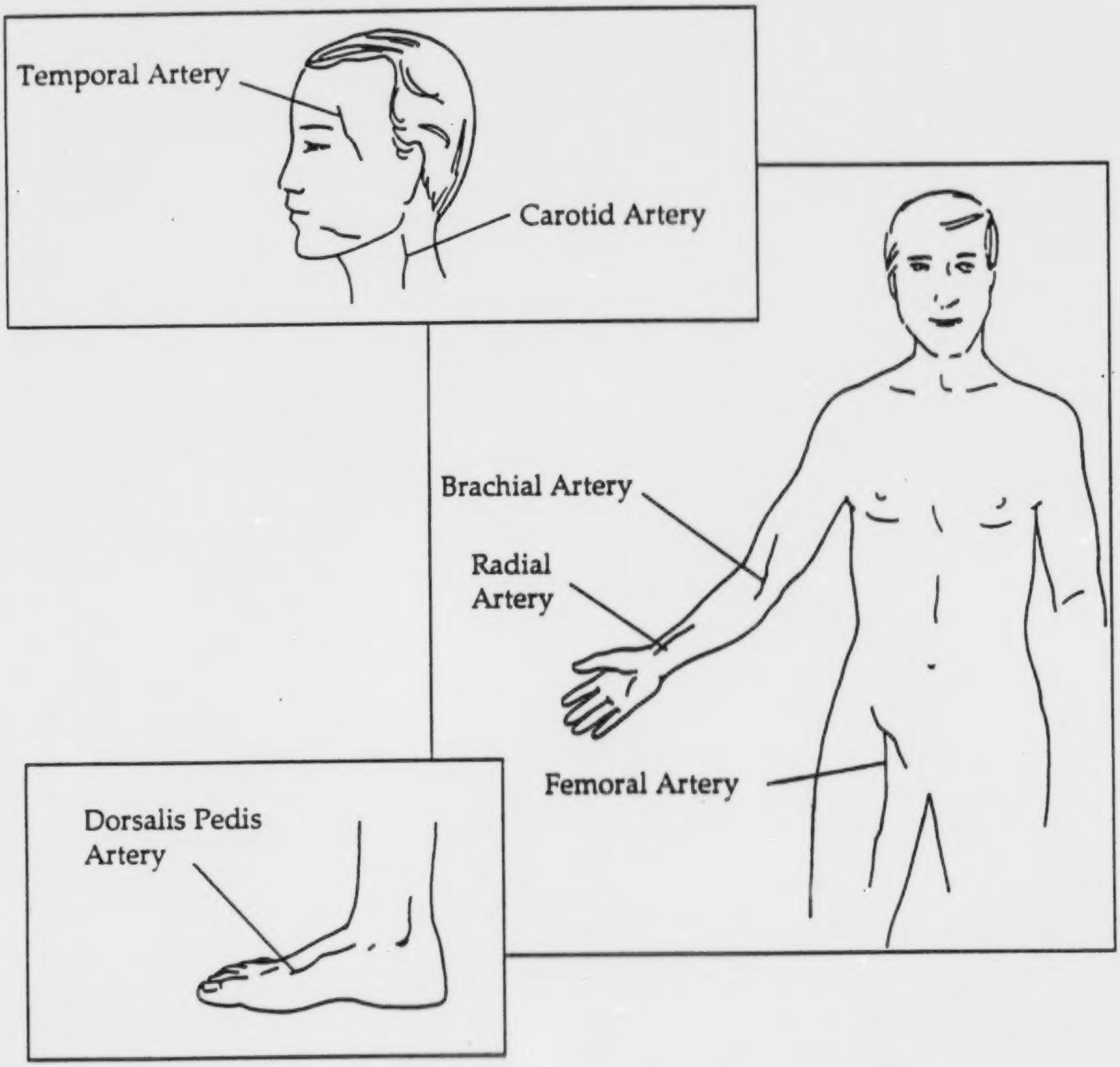
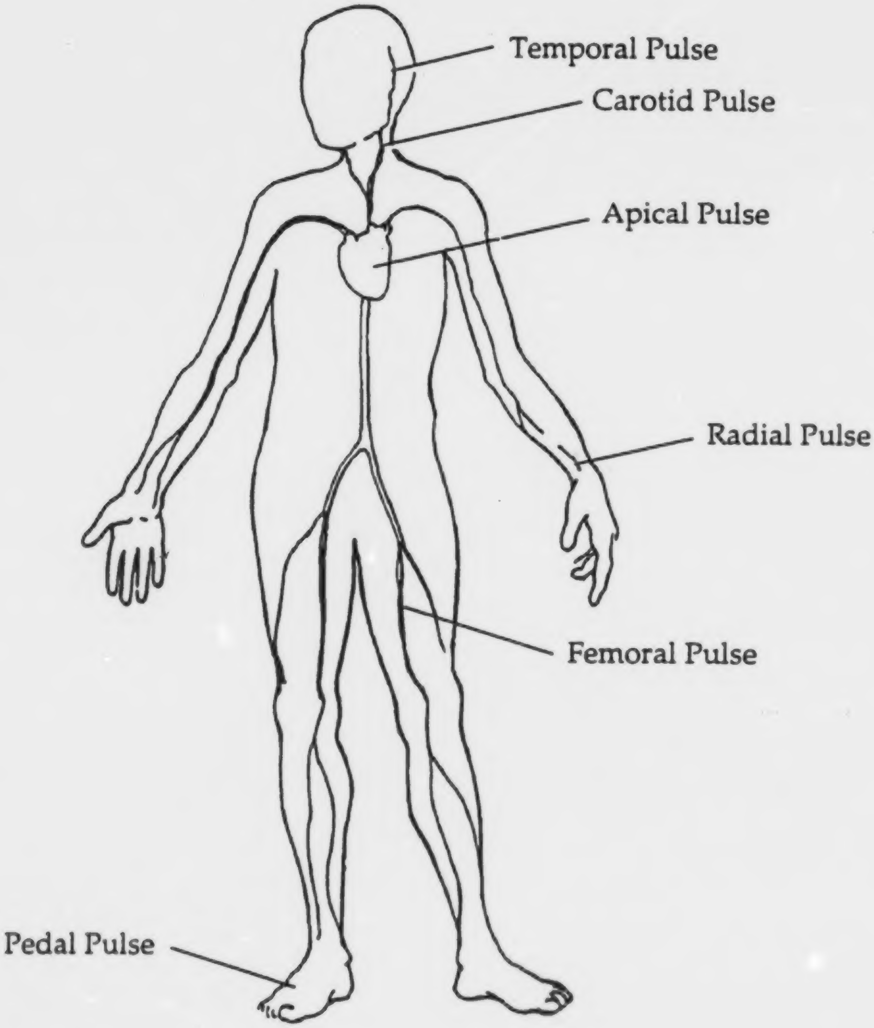
Rectal Thermometer

SITES FOR TAKING A PULSE


Temporal Artery
Carotid Artery
Brachial Artery
Radial Artery
Femoral Artery
Dorsalis Pedis Artery

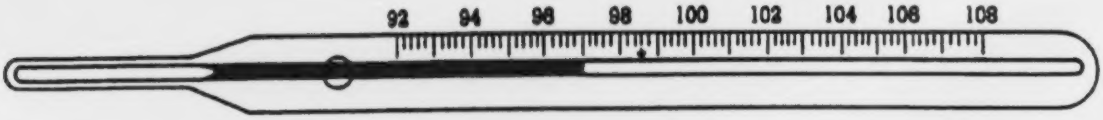
THE CIRCULATORY SYSTEM - PRIMARY PULSE POINTS


Temporal Pulse
Carotid Pulse
Apical Pulse
Radial Pulse
Femoral Pulse
Pedal Pulse

READING A THERMOMETER

1. Write the readings on these thermometers in the blanks to the right.

a. ____________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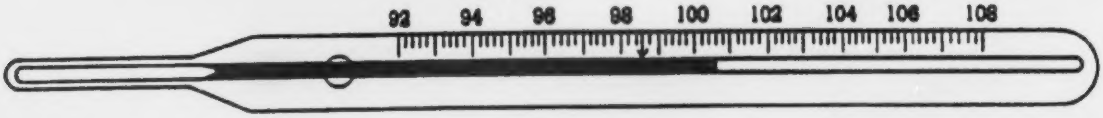
b. ____________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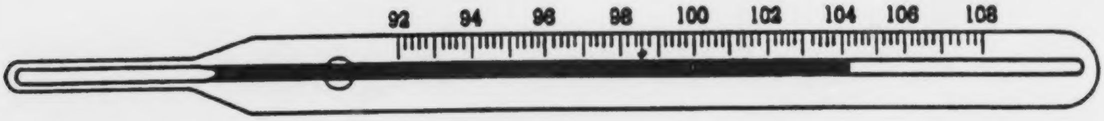
c. ____________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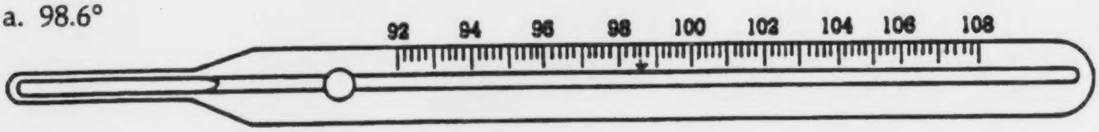
2. Mark the temperature readings on these thermometers.

a. 98.6°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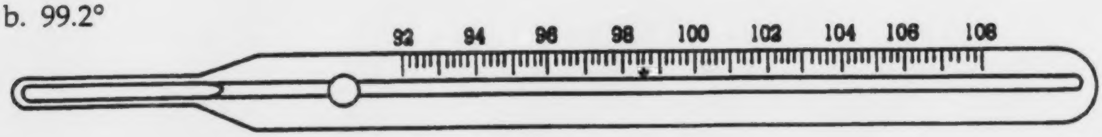
b. 99.2°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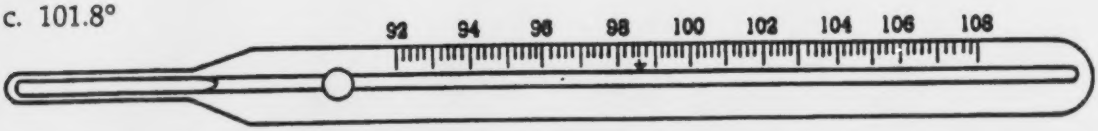
c. 101.8°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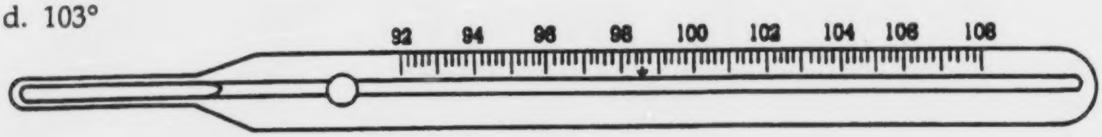
d. 103°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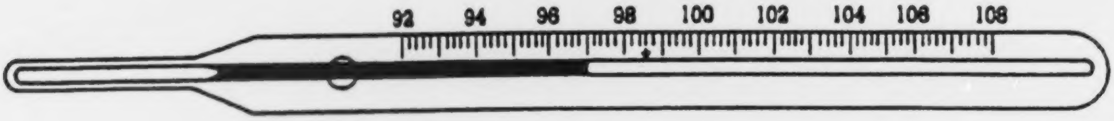
ANSWERS

1. Write the readings on these thermometers in the blanks to the right.

a. 97°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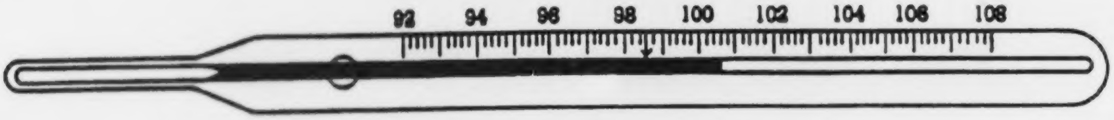
b. 100.6°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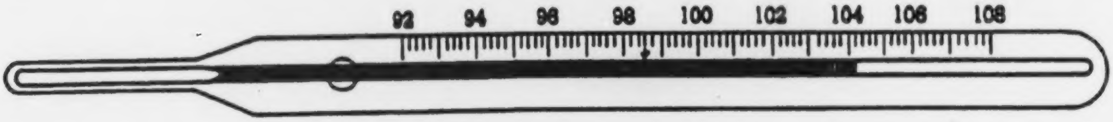
c. 104.2°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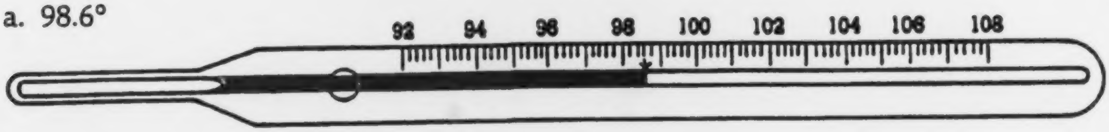
2. Mark the temperature readings on these thermometers.

a. 98.6°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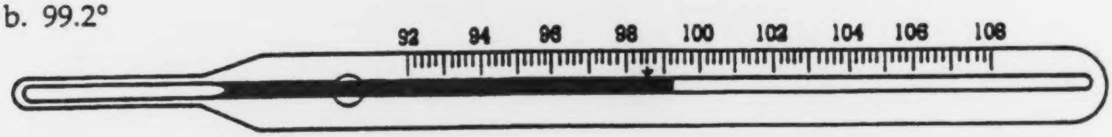
b. 99.2°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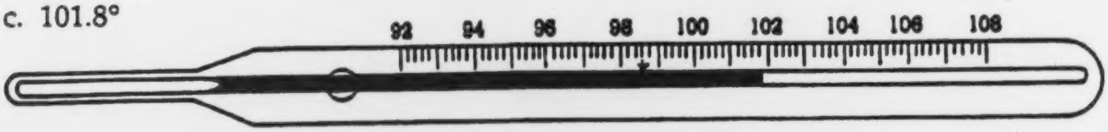
c. 101.8°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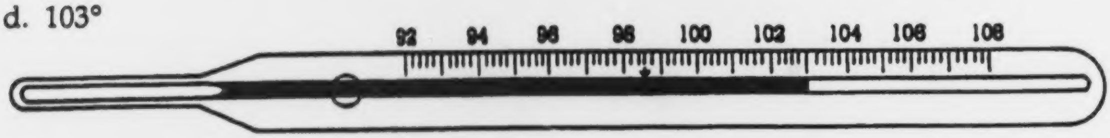
d. 103°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LESSON PLAN: 50

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

SCOPE OF UNIT:

The structure and function of the respiratory system are examined. Medical terms and definitions pertaining to respiratory system are introduced. Types of respiration, the respiratory process, and tuberculosis are discussed. Oxygen administration, including types of oxygen containers, methods used, and safety/comfort measures related to the client receiving oxygen therapy, and the procedure for collecting a sputum specimen are also included in this unit.

INFORMATION TOPIC: X-50 OR DEMONSTRATION:

RESPIRATORY SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match the terms in this lesson with their correct definitions.
2. Identify the three stages of respiration.
3. Match the structures of the respiratory system with their functions.
4. Define inspiration, expiration, and ventilation.
5. Match the respiratory disorders listed in this lesson with their correct descriptions.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Respiratory System
2. HO 2: Breathing
3. State Fair Community College Media Center, slide/tape #HO-R83-560: "The Upper Respiratory Tract"
4. American Lung Association films
5. Wall chart of respiratory system
6. American Lung Association - pamphlets on respiratory diseases

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 50 (Student Reference page 815) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

It is the function of the organs of respiration to provide a system for exchange of gases to and from the bloodstream. This exchange is accomplished by the inhaling and exhaling of air. We will look at the organs of respiration and how they function. A person can live only a few minutes without oxygen.

When caring for the elderly, you should remember that their lungs are less efficient at exchanging gases and this will effect their respiratory rate.

Turn the diagram of the respiratory system upside down. Does it look like a tree? As you study this lesson try to associate the parts of the respiratory system to a tree.

LESSON PLAN: 50

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

OUTLINE:

I. Terms (II-1)

A. Oxidation - the combination of a substance with oxygen

B. Fissures - clefts

C. Pneumothorax - lung collapses due to a build up of air in the pleura cavity

D. Thoracentesis - procedure to drain excessive fluid from the pleural cavity

E. Apnea - breathing stops temporarily

F. Dyspnea - painful, difficult, labored breathing

G. Eupnea - normal breathing

H. Hypoxia - oxygen deficiency

I. Stertorous respiration - abnormal snoring noises when breathing

J. Abdominal respiration - uses mostly the abdominal muscles to breath

K. Irregular respirations - the depth of breathing changes and the rate of the rise and fall of the chest is not steady

L. Hyperpnea - abnormal increase in depth and rate of respirations

M. Tachypnea - very fast respirations

N. Orthopnea - able to breath only in upright position

O. Cheyne-strokes - deep, rapid respirations for 30 seconds, no breathing for 10-30 seconds; cycle repeats

P. Bronchiectasis - dilatation of the bronchi

Q. Bronchitis - inflammation of the bronchi

R. Bronchoscopy - inspection or examination of the bronchi

S. Hemoptysis - spitting or coughing up blood

- T. Laryngitis - inflammation of the larynx
- U. Pharyngitis - inflammation of the pharynx
- V. Pleuritis - inflammation of the pleura
- W. Pneumonitis - inflammation of the lung
- X. Rhinitis - inflammation of the mucous membrane of the nose
- Y. Tracheotomy - incision into the trachea

II. Respiratory system

- A. Function of the respiratory system
    1. Supplies oxygen to the body cells
    2. Removes carbon dioxide from the body cells
    3. Filters, warms, and humidifies the air we breath
- B. Three stages of respiration (II-2)
    1. External - breathing or ventilation
        - a. Inhale oxygen into the body
        - b. Exhale carbon dioxide in the blood through the alveoli of the lungs
    2. Internal respiration
        - a. The exchange of carbon dioxide and oxygen between the cells and the lymph
        - b. Also the oxidative process of energy in the cells
    3. Cellular respiration or oxidation
        - a. A chemical reaction that occurs within the cells
        - b. When the food that you have eaten is oxidized, it gives off the waste products of carbon dioxide and water. They then are transported from the cells to the circulatory system and exhaled by the lungs.

III. Organs and Functions of Respiratory System (HO 1) (II-3)

- A. Nose - nasal cavity
    1. Structure

        a. Nostrils or anterior nares - air enters the respiratory system through the nostrils.

        b. Septum - it is the partition which divides the nasal cavity into a right and left chamber.

        c. Sinuses

            (1) Sinuses are cavities of the skull in and around the nasal region.

            (2) There are four sinuses:

                (a) Frontal

                (b) Maxillary

                (c) Sphenoid

                (d) Ethmoid

            (3) Sinuses connect to the nasal cavity by way of short ducts.

    2. Function

        a. Warms, moistens, and filters air

        b. Phonation

        c. Organ of smell

        d. Passageway for air

B. Pharynx - throat

    1. Structure

        a. Approximately 5 inches long

        b. Three sections

            (1) Nasopharynx

                (a) Adenoids and tonsils are located in the nasopharynx and also the oropharynx.

                (b) Eustachian tubes open into the nasopharynx.

            (2) Oropharynx - located behind the mouth

            (3) Laryngopharynx - lowest portion

    2. Function - passageway for air and food.

C. Larynx - voice box

    1. Structure

        a. Located below the pharynx; triangular shape

        b. Composed of several pieces of cartilage: thyroid cartilage and Adam's apple

        c. Vocal cords - two short fibrous bands that stretch across the interior of the larynx

        d. Epiglottis - partially covers the opening into the larynx. It closes off the larynx during swallowing so that food does not enter the trachea.

    2. Function - speech and phonation

D. Trachea - windpipe

    1. Structure

        a. About 4 1/2 inches long; tube-like passageway

        b. Extends from the larynx, and continues to form the two bronchi

        c. Composed of C-shaped hyaline cartilage

        d. Walls lined with mucous membrane and ciliated epithelium

    2. Function

        a. Passage-way for air

        b. Traps inhaled food particles

E. Bronchi, bronchiolus, and alveoli

    1. Structure

        a. They are smooth muscle lined with ciliated mucous membrane.

        b. Lower end of the trachea divides to form the right and left bronchi; right bronchus is shorter and wider than the left bronchus.

c. At the point where the bronchi enter the lungs, they subdivide into the bronchial tubes.

d. Alveolar duct is located at the end of each bronchiole.

e. Alveolar ducts end in a grape-like cluster called the alveoli.

2. Function

a. Passageway for air

b. Exchange of oxygen and carbon dioxide occurs in the alveoli.

F. Lungs

1. Structure

a. Located in the two lateral chambers of the thoracic cavity

b. Separated by the mediastinum and heart

c. Base is the lower part of the lung.

d. Right lung larger than left lung

e. Lobes

(1) Right lung - divided into 3 lobes: superior, middle, inferior

(2) Left lung - divided into 2 lobes: superior and inferior

f. Lungs are covered with a moist thin membrane called the pleura.

2. Linings - pleura

a. Visceral pleura or pulmonary pleura - lines lungs and between lobes

b. Parietal pleura - lines thoracic cavity and upper surface of diaphragm

3. Pleural cavity

a. Space between visceral pleura and parietal pleura

b. Contains pleural fluid

c. Pleural fluid prevents friction when you breath.

4. Function

        a. Transportation - air moves into and out of the lungs

        b. Remove gases

IV. Respiratory Process

- A. Control of breathing (HO 2)
    1. Medulla monitors amount of carbon dioxide in blood and controls respirations.
    2. Muscles of breathing are signalled to contract and expand by medulla.
        - a. Intercostals
        - b. Diaphragm
    3. Amount of carbon dioxide
- B. Inspiration - drawing of air into the lungs (II-4)
- C. Expiration - forcing air from the lungs
- D. Ventilation - combination of inspiration and expiration
- E. Respiratory rates
    1. Normal
        - a. Child - above 20
        - b. Adult - 14-20 per minute
    2. Factors affecting rate
        - a. Sex
        - b. Posture
        - c. Temperature
        - d. Exercise
        - e. Age
        - f. Drugs

V. Disorders of the Respiratory System (II-5)

A. Emphysema - air becomes trapped in the lungs because the wall of the alveoli becomes enlarged. People with emphysema develop oxygen deficiency.

B. Lung cancer - contributing factors are smoking and exposure to other environmental cancer-producing agents

C. Cancer of larynx - may require removal of the larynx and cause loss of the voice

D. Infections - pneumonia and influenza

E. Tuberculosis - (Refer to lesson on tuberculosis.)

F. COPD - Chronic Obstructive Pulmonary Disease - the condition develops due to prolonged blockage of the air passageways. It causes loss of alveoli and poor delivery of blood to the lungs. Conditions such as asthma, emphysema, and bronchitis cause COPD to develop

G. Bronchitis - inflammation in the bronchi due to infection or irritation

H. Influenza - characterized by inflammation of the mucous membrane of the respiratory system

I. Pneumonia - usually caused by a bacteria but can be caused by a virus; lungs fill up with inflammatory exudate.

J. Diphtheria - a very serious infectious disease that can lead to cardiac damage and even death. It is caused by the Corynebacterium diphtheria. There is a false, grayish-white, or yellow membrane that covers the pharynx, larynx, trachea, and tonsils.

K. Pertussis - (Whooping cough) coughing attacks that have a whooping sound; it is an infectious disease that can cause death in the very young

L. Asthma - characterized by labored breathing and coughing; an attack may be brought on by coming in contact with an allergen or by emotional stress

VI. Summary and Conclusion

A. Terms

B. Respiratory system

C. Organs and functions of respiratory system

D. Respiratory process

E. Disorders of the respiratory system

Your next lesson will be collecting a sputum specimen.

LESSON PLAN: 50

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms found in this lesson?
2. What are the three stages of respiration?
3. What is the function of each of the structures of the respiratory system?
4. How do you describe inspiration, expiration, and ventilation?
5. What is the description of each respiratory disorder listed in this lesson?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES

1. Invite a respiratory therapist to speak.
2. Follow respiratory process from inhalation of air on respiratory model.
3. Assign reports on various lung diseases, and the effects of smoking.
4. Show films.

ANSWERS TO EVALUATION ITEMS:

1. c
2. f
3. d
4. e
5. b
6. b
7. f
8. a
9. e
10. c
11. d
12. b
13. c
14. c
15. d
16. a
17. e
18. b

LESSON PLAN: 50
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT X: THE RESPIRATORY SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with their correct definitions in Column II.

		Column I		Column II
____	1.	Eupnea	a.	Oxygen deficiency
____	2.	Apnea	b.	Able to breathe only in upright position
____	3.	Fissures	c.	Normal breathing
____	4.	Dyspnea	d.	Clefts
____	5.	Orthopnea	e.	Painful, difficult, labored breathing
			f.	Breathing stops temporarily

6. What are the three stages of respiration? (Circle the letter of the best answer.)

   a. Shallow, slow, and speed
   b. External, internal, and cellular
   c. Warm, moist, and filter
   d. Inhale, breathe, and exhale

Match each structure of the respiratory system in Column I with the correct function in Column II.

Column I		Column II	
___ 7.	Nose	a.	Passageway for air and food
___ 8.	Pharynx	b.	Removes gases, air moves into and out of
___ 9.	Larynx	c.	Passageway for air and traps inhaled food particles
___ 10.	Trachea	d.	Exchange of oxygen and carbon dioxide
___ 11.	Alveoli	e.	Speech and phonation
___ 12.	Lungs	f.	Warms, moistens, and filters air

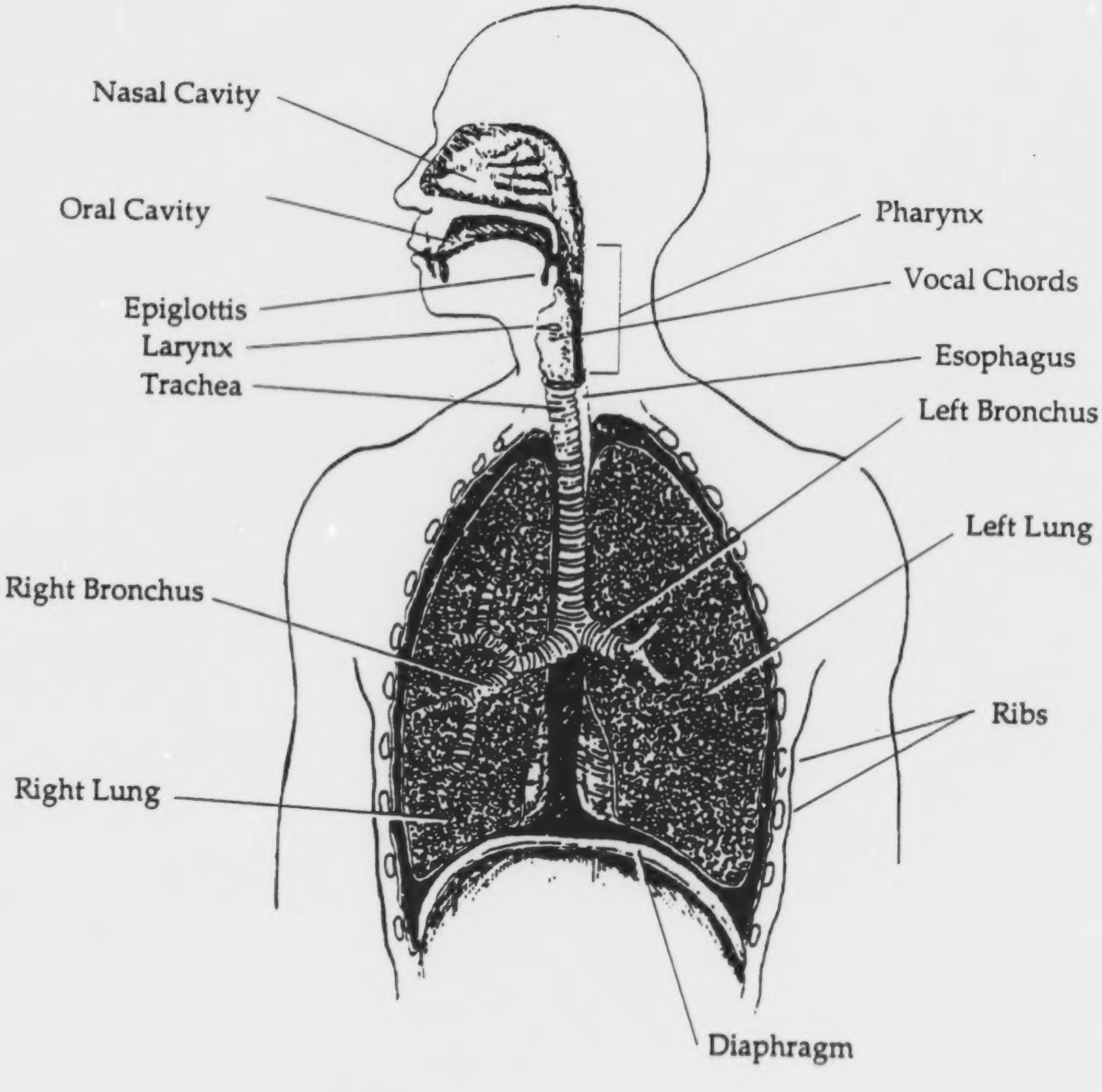
13. What is ventilation? (Circle the letter of the best answer.)

   a. Drawing air into the lungs
   b. Forcing air from the lungs
   c. A combination of inspiration and expiration
   d. Difficult, long, slow respirations

Match each respiratory disorder in Column I with the correct description of the disorder in Column II.

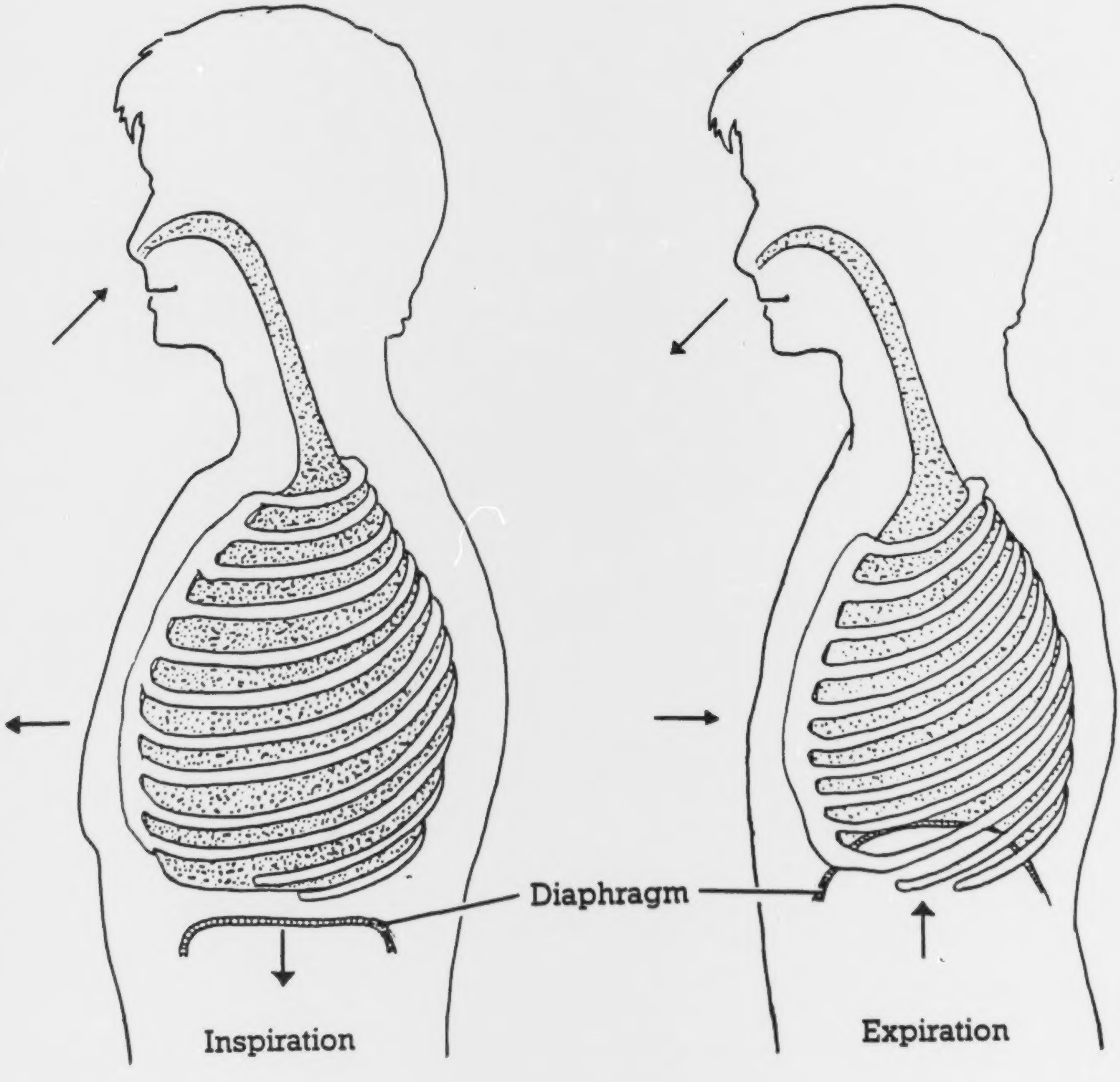
Column I		Column II	
___ 14.	Pertussis	a.	Chronic obstructive pulmonary disease
___ 15.	Emphysema	b.	Lungs fill up with inflammatory exudate
___ 16.	COPD	c.	There is a whooping sound to the cough
___ 17.	Diphtheria	d.	Air becomes trapped in the lungs because the wall of the alveoli becomes enlarged
___ 18.	Pneumonia	e.	There is a false, grayish-white, or yellow membrane that covers the pharynx, larynx, trachea, and tonsils

RESPIRATORY SYSTEM


Nasal Cavity
Oral Cavity
Epiglottis
Larynx
Trachea
Right Bronchus
Right Lung
Pharynx
Vocal Chords
Esophagus
Left Bronchus
Left Lung
Ribs
Diaphragm

BEST COPY AVAILABLE

BREATHING


Diaphragm
Inspiration
Expiration

LESSON PLAN: 51

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

SCOPE OF UNIT:

The structure and function of the respiratory system are examined. Medical terms and definitions pertaining to respiratory system are introduced. Types of respiration, the respiratory process, and tuberculosis are discussed. Oxygen administration, including types of oxygen containers, methods used, and safety/comfort measures related to the client receiving oxygen therapy, and the procedure for collecting a sputum specimen are also included in this unit.

INFORMATION TOPIC: X-51 AND DEMONSTRATION: X-51

COLLECT A SPUTUM SPECIMEN
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Describe saliva and sputum.
2. Describe the purpose of obtaining a sputum specimen.
3. Identify important points to remember when collecting a sputum specimen.

Demonstration

4. Collect a sputum specimen.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Sputum specimen container with lid
2. Tissue
3. Glass of water
4. Label
5. Requisition for laboratory
6. Paper bag

7. Gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 51 (Student Reference page 827) prior to class and be prepared to discuss the information and return the demonstration on collecting a sputum specimen.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

DeWit, Susan C. Keane's Essentials of Medical-Surgical Nursing, 3rd ed. Philadelphia, W.B. Saunders Co., 1992.

Hegner, Barbara R.; Ester Caldwell. Geriatric A Study of Maturity, 5th ed. Albany, NY: Delmar Publishers, 1991.

INTRODUCTION:

Sputum is the mucous secretions expelled from the lungs, bronchi, and trachea. A sputum specimen can aide the doctor in diagnosing an illness. It is important to follow the procedure when collecting a sputum specimen.

LESSON PLAN: 51

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Saliva (spit) - a clear, thin substance produced by the salivary glands in the mouth

   B. Sputum - mucous secretions expelled from the lungs, bronchi, and trachea

II. Purpose of Obtaining a Sputum Specimen (II-2)

   A. To do laboratory test for the presence of blood, microorganisms, and abnormal cells

III. Points to Remember When Collecting a Sputum Specimen (II-3)

   A. Always have the client rinse his/her mouth with water to remove food and saliva prior to collecting the specimen.

   B. Never have the client use mouthwash before collecting the sputum specimen. Mouthwash can destroy some of the microorganisms and may give a false laboratory report.

   C. Sputum specimens should be collected early in the morning.

   D. Always instruct the client to take three deep breaths and on the third, exhale and cough deeply from the bronchi, trachea, and lungs.

   E. Do not use saliva and nose secretions for this test.

   F. Always use an approved facility container to collect and transport the specimen.

   G. Taking deep breaths, coughing, and bringing up sputum can be difficult and painful to the client.

   H. One to two tablespoons is the usual amount of sputum required for a specimen.

   I. Always report the following:

      1. The time you collected the specimen and time you took it to the laboratory or what you did with it

    2. The amount of sputum collected

    3. Any difficulty the client had raising the sputum

    4. Consistency and appearance of the sputum: clear, white, green, yellow, blood-tinged, or thick

IV. Demonstrate Procedure for Collecting a Sputum Specimen

V. Summary and Conclusion

  A. Terms and definitions

  B. Purpose of obtaining a sputum specimen

  C. Points to remember when collecting a sputum specimen

  D. Review procedure for collecting a sputum specimen

We have discussed important information and the correct procedure for collecting a sputum specimen. The next lesson is oxygen therapy.

LESSON PLAN: 51
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT X: THE RESPIRATORY SYSTEM

STEPS OF PROCEDURE - COLLECT A SPUTUM SPECIMEN:

1. Assemble equipment.
2. Explain the procedure to client.
3. Fill out laboratory requisition slip with required information.
4. Wash your hands. Put on gloves.
5. Have client rinse out mouth with water.
6. Have client hold the container.

   NOTE: Instruct him/her to only touch the outside of the container.
7. Instruct client to cover his/her mouth and nose with tissue when he/she coughs.
8. Instruct client to take three deep breaths in a row and on the third, exhale and cough deeply from within the lungs to bring up the sputum.
9. Have the client expectorate directly into the container.
10. Collect one to two tablespoons of sputum.
11. Immediately put lid on container.
12. Place container in a bag and attach requisition slip.
13. Remove, clean, and store equipment used.
14. Remove gloves and wash hands.
15. Make the client comfortable; place call signal within reach.
16. Take the specimen to the laboratory or store according to facility policy.
17. Report any observations to the charge nurse.

LESSON PLAN: 51

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X : THE RESPIRATORY SYSTEM

INTERACTION ITEMS:

1. **What do saliva and sputum mean?**
2. **Why is a sputum specimen collected?**
3. **What points should the health care assistant remember when collecting a sputum specimen?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Instructor should demonstrate collecting a sputum specimen.**
2. **Students collect sputum specimens.**

ANSWERS TO EVALUATION ITEMS:

1. d
2. d
3. c

LESSON PLAN: 51

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

EVALUATION ITEMS:

1. The correct description of sputum is: (Circle the letter of the best answer.)
    a. A clear substance produced by nasal drainage.
    b. A substance produced by the salivary glands in the mouth.
    c. Spit which we bring up early in the morning.
    d. Mucous secretions expelled from the lungs.

2. The purpose of obtaining a sputum specimen is to do laboratory tests for the presence of: (Circle the letter of the best answer.)
    a. Blood.
    b. Microorganisms.
    c. Abnormal cells.
    d. All of the above.

3. When collecting a sputum specimen, the health care assistant should remember to: (Circle the letter of the best answer.)
    a. Instruct the client to rinse his/her mouth with mouthwash prior to collecting the specimen.
    b. Collect nose and saliva secretions along with the sputum.
    c. Collect the sputum specimen early in the morning.
    d. Collect 1/2 teaspoon sputum for the specimen.

LESSON PLAN: 51

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X : THE RESPIRATORY SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

COLLECT A SPUTUM SPECIMEN

EQUIPMENT:

1. Sputum specimen container with lid
2. Tissue
3. Glass of water
4. Label
5. Requisition for laboratory
6. Paper bag
7. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Assemble equipment.		
2. Explain the procedure to client.		
3. Fill out laboratory requisition slip with required information.		
4. Wash your hands. Put on gloves.		
5. Have client rinse out mouth with water.		
6. Have client hold the container. NOTE: Instruct him/her to only touch the outside of the container.		
7. Instruct client to cover his/her mouth and nose with tissue when he/she coughs.		
8. Instruct client to take three deep breaths in a row and on the third, exhale and cough deeply from within the lungs to bring up the sputum.		
9. Have the client expectorate directly into the container.		
10. Collect one to two tablespoons of sputum.		
11. Immediately put lid on container.		
12. Place container in a bag and attach requisition slip.		
13. Remove, clean, and store equipment used.		

14.	Remove gloves and wash hands.		
15.	Make the client comfortable; place call signal within reach.		
16.	Take the specimen to the laboratory, or store according to facility policy.		
17.	Report any observations to the charge nurse.		

The student has satisfactorily completed the procedure "COLLECTING A SPUTUM SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 52

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

SCOPE OF UNIT:

The structure and function of the respiratory system are examined. Medical terms and definitions pertaining to respiratory system are introduced. Types of respiration, the respiratory process, and tuberculosis are discussed. Oxygen administration, including types of oxygen containers, methods used, and safety/comfort measures related to the client receiving oxygen therapy, and the procedure for collecting a sputum specimen are also included in this unit.

INFORMATION TOPIC: X-52 OR DEMONSTRATION:

OXYGEN THERAPY
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List two types of oxygen containers.
2. List two methods of administering oxygen.
3. Identify five safety measures to follow when administering oxygen.
4. Identify five comfort measures to follow when administering oxygen.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Oxygen tank
2. Plastic mask
3. Nasal cannula

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 52 (Student Reference page 833) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 18.

Hegner, Barbara; Ester Caldwell. Nursing Assistant, A Nursing Process Approach. 6th ed. Albany, NY: Delmar Publisher, 1992. Unit 23, Section 10.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 12, Section 2.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 13.

INTRODUCTION:

Oxygen is a colorless, odorless, tasteless gas that is absolutely necessary to life. Because of a disease or condition, the client may not be able to breathe in enough oxygen on his/her own.

Oxygen is considered a drug. The doctor must order it to be administered. The health care assistant will never be responsible for the oxygen; however, he/she will be assigned to take care of clients who are receiving oxygen and should be familiar with the equipment used and basic safety and comfort measures to follow.

LESSON PLAN: 52

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

OUTLINE:

I. Oxygen Containers (II-1)

- A. Oxygen cylinder or tank
- B. Central oxygen system with wall outlet connector
- C. Machines that remove oxygen from room air (oxygen concentrator)

II. Methods of Administration of Oxygen (O_2) (II-2)

- A. Nasal cannula
  1. Two prongs leading from the tubing are placed in each nostril and held in place by an elastic strap around the head. The prongs should be angled back into the nostrils.
  2. Plastic tubing connects oxygen source container to the cannula.
  3. This is the most common device used to administer O_2.
  4. Client should not breathe through his or her mouth since the oxygen will go out the opened mouth.
- B. Mask
  1. Plastic mask placed over the nose and mouth and fitted to nose with metal adjuster
  2. Used for the client who is breathing through his/her mouth
  3. The most effective way of delivering oxygen

III. Safety Measures (II-3)

- A. Oxygen speeds up combustion
  1. Post "No Smoking" signs outside and inside the room when oxygen is set up.
  2. Remove electrical equipment from the room before administering oxygen.

3. Do not use oil-based products (e.g., vaseline®, body lotion) in the room where oxygen is being administered.

4. Use clothes and bed linens made of cotton to avoid static electricity from synthetic or wool fabrics (e.g., wool blankets or sweaters).

B. Check to see that portable oxygen tanks are secured with straps to prevent them from falling.

C. Check the oxygen gauge indicating the amount of oxygen left in the tank; notify the charge nurse if the supply is low.

D. Check the tubing for kinks and disconnections.

E. Check to see that the client is not lying on the tubing.

F. Check flowmeter on oxygen tank to make sure it is delivering the prescribed rate; DO NOT change the setting; report to the charge nurse immediately if it is not correct.

G. Check water level in humidifying jar; it should be high enough (2/3 full) so that it bubbles as oxygen goes through it. It should also appear clear--no particulate matter. If anything appears abnormal, report to charge nurse. Remember pure oxygen is very drying and thus is damaging to tissue. (II-4)

H. Oxygen should be turned off when not being administered to the client.

IV. Comfort Measures (II-5)

A. Check the elastic headband securing face mask or cannula in place to see that it is not too tight and causing pressure areas.

B. Check for irritation from the mask or cannula around the face and ears; pad pressure areas with cotton.

C. Keep the skin under cannula or mask clean and dry.

D. Give frequent oral hygiene and adequate fluids to the client; oxygen is drying to tissue thus causing the mouth to become dry and stale tasting.

E. Remove and wipe face mask every shift to rid mask of moisture.

F. Check nasal cannula for mucus buildup. Replace if it is plugged.

G. Check that face mask is snug and not allowing oxygen to be ineffective.

H. Observe for any signs and symptoms that client is not getting enough oxygen and report immediately to the charge nurse.

1. Client feels like he/she "can't breathe."

2. Restless, irritable, anxious, or frightened

3. Decreased muscle coordination and slowed mental abilities

4. Dyspnea or cyanosis

5. Increased rate and depth of respirations

6. Client complains of dizziness or faintness

V. Summary and Conclusion

A. Oxygen containers

B. Methods of administering oxygen

C. Safety measures

D. Comfort measures

The health care assistant's role in oxygen therapy is to make pertinent observations. Clients receiving oxygen may not be a common occurrence in every facility, but all health care assistants should have an understanding of how dangerous this can be if not handled properly and what he/she can do to keep the client comfortable while receiving oxygen. The next lesson will be on tuberculosis.

LESSON PLAN: 52

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

INTERACTION ITEMS:

1. **What are three types of oxygen containers?**
2. **What are two common methods of administering oxygen?**
3. **What safety measure actions should the health care assistant take if the client is receiving oxygen?**
4. **Why is it necessary to humidify oxygen?**
5. **What comfort measures are important for the client receiving oxygen?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Show students different equipment used in oxygen therapy.**

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:
    a. Oxygen cylinder or tank
    b. Central oxygen system with wall outlet connector
    c. Machines that remove oxygen from room air

2. a Nasal cannula
    b. Mask

3. d
4. d
5. c
6. b

LESSON PLAN: 52

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

EVALUATION ITEMS:

1. List two types of oxygen containers.

   a.
   b.

2. List two methods of administering oxygen.

   a.

   b.

3. If a client is receiving oxygen, the health care assistant should do all of the following except: (Circle the letter of the best answer.)

   a. Check to see that portable oxygen tanks are secure.
   b. Check tubing for kinks and disconnections.
   c. Make sure the client is not lying on the tubing.
   d. Change the flowmeter to what you feel is the right amount of oxygen.

4. Which of the following is a sign that the client is not getting enough oxygen? (Circle the letter of the best answer.)

   a. Restless, anxious
   b. Dyspnea, cyanosis
   c. Dizziness or faintness
   d. All of the above

5. What safety measure should the health care assistant follow if the client is receiving oxygen? (Circle the letter of the best answer.)

   a. Use oil-based products on the client.
   b. Use wool bed blankets to improve static electricity.
   c. Post a "no smoking" sign outside and inside the room.
   d. Make certain the water level in the humidifying jar is less than 1/4 full.

6. To make certain the client receiving oxygen is comfortable, the health care assistant should: (Circle the letter of the best answer.)

   a. Check that the face mask is fitting loosely.
   b. Check for irritation from the mask or cannula around the face.
   c. Keep the skin under the cannula moist.
   d. Never remove the face mask once it is in place.

LESSON PLAN: 53

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

SCOPE OF UNIT:

The structure and function of the respiratory system are examined. Medical terms and definitions pertaining to respiratory system are introduced. Types of respiration, the respiratory process, and tuberculosis are discussed. Oxygen administration, including types of oxygen containers, methods used, and safety/comfort measures related to the client receiving oxygen therapy, and the procedure for collecting a sputum specimen are also included in this unit.

INFORMATION TOPIC: X-53 OR DEMONSTRATION:

TUBERCULOSIS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms found in this lesson with their correct definitions.
2. Name the causative organism of tuberculosis.
3. Name two skin tests that are given to determine if an individual has been infected with the tubercle bacillus.
4. List the symptoms of tuberculosis.
5. Identify how tuberculosis is spread.
6. Name the vaccine given that offers protection from contracting tuberculosis.
7. Name the drug used as preventive therapy for individuals exposed to tuberculosis.
8. Identify treatment given for tuberculosis.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 53 (Student Reference page 839) prior to class and be prepared to discuss the information.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

DeWit, Susan C. Keane's Essentials of Medical-Surgical Nursing, 3rd ed. Philadelphia: W.B. Saunders Co., 1992.

Hegner, Barbara R.; Ester Caldwell. Geriatric A Study of Maturity, 5th ed. Albany, NY: Delmar Publishers, 1991.

Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly: Recommendation of the Advisory Committee for Elimination of Tuberculosis. Atlanta, GA. U.S. Department of Health and Human Services, Center for Disease Control.

INTRODUCTION:

The incubation period for tuberculosis is four to 12 weeks from infection to the primary lesion. The disease remains infectious as long as the tubercle bacilli is discharged in the sputum.

The health care assistant may care for clients who have not been diagnosed as having tuberculosis but have the disease. It is also possible to work with someone who has the disease but has not yet been diagnosed. This is why skin testing of health care workers and all new clients to long-term care facilities is so important.

LESSON PLAN: 53

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

  A. Extrapulmonary - refers to tuberculosis outside the lungs.

  B. Lymph nodes - small nodules of specialized immune cells located throughout the body (also called lymph glands or glands)

  C. Mantoux tuberculin skin test - tuberculin test given by injecting 0.1 ml of PPD-tuberculin into the superficial layers of the skin (usually in the forearm) with a needle and syringe; the most reliable and best standardized technique for tuberculin testing

  D. *Mycobacterium tuberculosis* - the bacterium which causes TB; often abbreviated *M. tuberculosis*

  E. Pulmonary - referring to the lungs

  F. Hemoptysis - coughing up blood

  G. Tubercle bacilli - term often used to refer to *Mycobacterium tuberculosis* (and to *Mycobacterium bovis*)

  H. Tubercle - walled off area

  I. Necrotic - the change that occurs as a result of the death of cells

  J. Fibrosis - fibrous tissue fotmation

II. Description

  A. Tuberculosis is an infectious disease of the lungs characterized by lesions within the lung tissue. Approximately 85 percent of the cases in the U.S. are pulmonary TB.

  B. The lesions may continue to degenerate and become necrotic, or they may heal by fibrosis and calcification.

  C. The tubercle bacillus is the causative organism. (II-2)

D. It can occur in other parts of the body. It is called extrapulmonary if TB occurs outside of the lungs, such as in the kidneys and lymph nodes. About 15 percent of the cases in the U.S. are extrapulmonary.

III. Diagnosis

A. Mantoux and Tine skin tests - The Mantoux is the most accurate. **(II-3)**

1. The test is read 48 to 72 hours after the injection.

2. If the swelling at the site of injection is more than 10 to 15 mm, the test is positive.

3. Some people who are infected with both HIV and TB germs will not react to the TB skin test. This is because the immune system is not working properly.

4. A positive tuberculin test does not tell you if the individual has active or inactive tuberculosis. It only indicates that the individual has been infected with the tubercle bacillus.

B. Chest X-ray - usually the doctor can see calcified and healed lesions and active lesions on an x-ray.

C. Sputum specimen - the diagnosis of active TB is made when the tubercle bacillus is found in the sputum.

IV. Symptoms

A. General symptoms

1. Weakness

2. Feeling sick

3. Weight loss

4. Fever - low grade in the afternoon

5. Night sweats

B. Common symptoms

1. Long-term cough

2. Chest pain

3. Coughing up blood (hemoptysis)

V. How is tuberculosis spread? **(II-5)**

A. Airborne - coughing, sneezing, laughing, or singing

B. Easily spread to others who have the same living space

VI. Immunity - BCG (Bacille Calmette-Gueren) vaccine offers some protection. **(II-6)**

VII. Preventive Therapy

A. Isoniazid (INH) is approximately 85% effective if a person has been exposed to tuberculosis. **(II-7)**

B. Isoniazid (INH) is usually given one time a day for a year.

VIII. Treatment

A. Medical treatment

1. Drugs are usually given in a combination of two or three (Example: Isoniazid (INH), Rifampin (RMP), and Ethambutol). The choice of drugs will depend upon many factors and will be ordered by the physician.

2. It usually takes 2 to 3 months of drug therapy for sputum smears to be negative.

a. The individual is allowed to return home after one negative sputum smear.

b. The individual is usually allowed to go back to work after three negative smears.

3. Many individuals with tuberculosis are treated at home and are not hospitalized.

B. Surgical treatment - sometimes it is necessary to remove the affected part of the lung.

IX. Summary

A. Terms and definitions

B. Description

C. Diagnosis

D. Symptoms

E. How is tuberculosis spread

F. Immunity

G. Preventive therapy

H. Treatment

It is very important that all contacts of an individual with active tuberculosis be reported. The individual and all contacts need to be educated on how the disease is spread and the importance of taking all medications as prescribed by the physician. The next unit is on the nervous system.

LESSON PLAN: 53

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

INTERACTION ITEMS:

1. **What are the definitions of terms defined in this lesson?**
2. **What organism causes tuberculosis?**
3. **What two skin tests are given to determine if an individual has been infected with the tubercle bacillus?**
4. **What are eight (8) symptoms of tuberculosis?**
5. **How is tuberculosis spread?**
6. **What vaccine is given to protect individuals from TB?**
7. **What medication is given to individuals exposed to tuberculosis?**
8. **What is the medical and surgical treatment for tuberculosis?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Have the class write or call for information about tuberculosis:**

   Missouri Department of Health
   P.O. Box 570
   Jefferson City, MO 65102-0570

   Phone 1-314-751-6400

2. **Have a class discussion on the living conditions that could lead to the spread of tuberculosis.**

ANSWERS TO EVALUATION ITEMS:

1. b
2. e
3. f
4. d
5. c
6. b
7. Mantoux and Tine

8. weakness
   feeling sick
   weight loss
   fever
   night sweats
   cough
   chest pain
   coughing up blood
9. d
10. c
11. Isoniazid
12. drugs
13. lung

LESSON PLAN: 53

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT X: THE RESPIRATORY SYSTEM

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

	Column I		Column II
____ 1.	Fibrosis	a.	Small nodules of immune cells
____ 2.	Hemoptysis	b.	Fibrous tissue formation
____ 3.	Tubercle	c.	Referring to the lungs
____ 4.	Necrotic	d.	Change that occurs as a result of the death of cells
____ 5.	Pulmonary		
		e.	Coughing up blood
		f.	Walled off area

6. The causative organism for tuberculosis is the tubercle: (Circle the letter of the best answer.)

   a. Virus.
   b. Bacillus.
   c. Staph.
   d. Strep.

7. Two skin tests given to determine if an individual has been infected with the organism that causes tuberculosis are the ________________________ and ________________________.

8. List eight symptoms of tuberculosis.

   a.

   b.

   c.

   d.

   e.

   f.

   g.

   h.

9. Tuberculosis is spread by: (Circle the letter of the best answer.)

   a. Feces specimens.
   b. Blood samples.
   c. Urine specimens.
   d. Airborne particles.

10. The vaccine given to protect individuals exposed to tuberculosis is: (Circle the letter of the best answer.)

   a. Isoniazid.
   b. Gamma globulin.
   c. Bacille calmette-gueren.
   d. ELISA.

11. The medication given to individuals exposed to tuberculosis is ________________.

12. The medical treatment for tuberculosis consists of giving a combination of two or three ______________________.

13. The surgical treatment of tuberculosis consists of sometimes removing the affected part of the ____________________.

LESSON PLAN: 54

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XI : THE NERVOUS SYSTEM

SCOPE OF UNIT:

The structure and function of the nervous system are examined. The medical terms and definitions pertaining to the nervous system are included. Conditions and changes related to the nervous system are also covered in this unit.

INFORMATION TOPIC: XI-54 OR DEMONSTRATION:

NERVOUS SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with their correct definitions.
2. State the qualities which enable the nervous system to act as a communication network.
3. Describe a neuron.
4. Identify the three types neurons.
5. Name the three divisions of the nervous system.
6. Identify on a diagram the cerebrum, cerebellum, pons, medulla, and spinal cord.
7. Label on a diagram the parts of the brain.
8. Match the divisions of the brain with their functions.
9. Describe the number of spinal and cranial nerves.
10. Name the two divisions of the autonomic nervous system.
11. Match conditions of the nervous system with their definitions.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Neuron

2. HO 2: The Brain

3. HO 3: Reflex Arc

4. HO 4: The Nervous System

5. Anatomy charts

6. Anatomical model - brain

7. State Fair Community College Media Center slide/tape #HO-81-570: Overview of the Nervous System

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 54 (Student Reference page 845) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

The communications system of our bodies is the nervous system. It controls and organizes all our body activities, both voluntary and involuntary. It is made up of the brain, the spinal cord, and nerves.

LESSON PLAN: 54

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XI : THE NERVOUS SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

  A. Ganglia - a group of cell bodies outside the central nervous system that carry impulses to involuntary muscles and glands

  B. Irritability - react when stimulated

  C. Conductivity - ability to transmit to distant points

  D. Axon - structure of a nerve cell that carries impulses away from the cell body to the dendrites

  E. Dendrites - a process of the nerve cell that carries impulses toward the cell body

  F. Fissure - deep groves of a structure

  G. Gray matter - matter that contains naked nerve fibers

  H. Afferent nerve - carries nerve impulses from the periphery to the central nervous system; a sensory nerve

  I. Receptor - sensory nerve that receives a stimulation and transmits it to the central nervous system

  J. Cephalalgia - headache

  K. Encephalitis - inflammation of the brain

  L. Neuralgia - painful nerves, nerve pain

  M. Neuritis - inflammation of a nerve

  N. Poliomyelitis - inflammation of the gray matter of the spinal cord

  O. Psychosomatic - pertaining to the mind body relationship

II. The Nervous System as a Communication Network (II-2)

  A. Able to receive stimuli

  B. Responds by producing nerve impulses

C. Conducts and coordinates neural information to and from the brain and spinal cord

III. Neurons - Nerve Cell (HO 1) **(II-3)**

A. Structure

1. Cell body - contains nucleus, found only in gray matter of the brain

2. Dendrites - projection that transmits impulses to the neuron cell. There may be several dendrites.

3. Axon - transmit impulses away from the neuron cell. There is only one Axon.

4. Synapse - the functional junction between two neurons

B. Types **(II-4)**

1. Sensory (afferent) - carry impulses toward the spinal cord and brain.

2. Motor (efferent) - carry messages from the brain and spinal cord to glands and muscles.

3. Connecting (associative) - carry impulses from one neuron to another.

C. Nerve fibers

1. Myelin

2. Neurilemma - nerve sheath

IV. Divisions of the Nervous System (HOs 2, 3, & 4) **(II-5 - 7)**

A. Central nervous system

1. Brain

a. Cerebrum

(1) Largest area of the brain located in the upper part of the skull at the highest point

(2) Divided into two hemispheres by the longitudinal fissure; each cerebral hemisphere is divided into lobes that correspond to the cranial bones which they lay over

(a) Longitudinal fissure - divides the cerebrum into two hemispheres

- (b) Transverse fissure - divides the cerebrum from the cerebellum
- (c) Central fissure or fissure of Rolando - divides the frontal from the parietal lobe
- (d) Lateral fissure or fissure of Sylvius - divides the frontal and temporal lobes
- (e) Parieto-occipital fissure - separates the occipital lobe from the parietal and temporal lobes

(3) Function

- (a) Frontal lobe - controls the motor functions of our body
- (b) Parietal lobe
  - i) Receives and interprets nerve impulses for pain, touch, heat, and cold
  - ii) Helps to determine distances, sizes, and shapes
- (c) Occipital lobe - controls eyesight
- (d) Temporal lobe - controls hearing and smell
- (e) Cerebral cortex - controls conscious thought, memory, reasoning, judgement, and will power

b. Diencephalon - two major structures

(1) Thalamus

- (a) Located inside each of the cerebral hemispheres
- (b) Functions as a relay station for incoming and outgoing nerve impulses

(2) Hypothalamus

- (a) Located below the thalamus
- (b) Functions
  - i) Regulates parasympathetic and sympathetic systems
  - ii) Regulates the constriction and dilation of blood vessels and controls the beating of the heart

iii) Helps to maintain normal body temperature

iv) Helps to regulate the amount of food we eat

v) Helps regulate water balance

vi) Causes an increase of intestinal peristalsis and secretions from the intestinal glands

vii) How we react to fear and pleasure

viii) Sleep control

c. Cerebellum

(1) Located behind the pons and below the cerebrum

(2) All skeletal muscle activity is carried out in the cerebellum.

(3) Function

(a) Helps the body maintain its balance

(b) Maintains muscle control

(c) Helps muscles to contract when they should, with the right amount of strength, and with the right amount of time for the movement the body is performing

d. Brain stem - made up of three parts

(1) Pons

(a) Located between the front of the cerebellum and between the medulla oblongata and midbrain

(b) Functions as a conductive pathway for nerve impulses of the brain and nervous system; contains the center that controls respiration

(2) Medulla oblongata

(a) Located between the spinal cord and the pons

(b) Acts as a passageway for nerve impulses between the brain and spinal cord

i) Slows heart rate

ii) Controls depth and rate of respiration

iii) Controls dilation and constriction of blood vessels

(3) Midbrain

e. Meninges - membranous coverings of the brain

(1) Dura mater - outer brain covering which lines the skull on the inside

(2) Arachnoid - middle layer

(3) Pia mater - covers the brain surface

f. Cerebrospinal fluid - fills the space between the arachnoid and pia mater; produced in the ventricles of the brain

(1) Nutrition

(2) Excretion

(3) Protection - shock absorber

2. Spinal cord

a. Location - starts at the medulla and continues downward; contained within the spinal column

b. Function - reflex center and conduction pathway to and from the brain

c. Stimuli

(1) Mechanical

(2) Physical

(3) Chemical

d. Reflex act

B. Peripheral nervous system (HO 3) - nerves of the body; connects the central nervous system to the body structures **(II-8)**

1. Cranial nerves - 12 pairs

2. Spinal nerves - 31 pairs

C. Autonomic nervous system

1. Consist of peripheral nerves and ganglia

2. Controls the involuntary, or automatic, activities of our internal organs

3. Made up of two divisions

    a. Sympathetic - prepares our bodies for action when we are afraid, angry, or in a stressful situation

    b. Parasympathetic - will counteract the effect

4. Our emotions influence both divisions.

5. Both divisions are antagonistic to each other; they keep our bodies in balance.

V. Conditions and Changes of the Nervous System

A. Nervous system changes with aging

1. Receptors become less sensitive. For example, the elderly may not be able to see or hear as well.

2. There is a diminished sensitivity to heat and pain. For example, the elderly may burn themselves with hot water.

3. The elderly have slower reflexes. Their balance is not as good as when they were younger and movement cannot be as well coordinated.

4. They don't think as fast, but his does not mean that their intelligence has diminished.

B. Conditions of the nervous system

1. Tolerance to stress is lower in elderly.

2. Confusion - (to be covered in unit XVI)

3. Delusions - delusions are the false interpretation of information despite all evidence to the contrary. The client may think there is someone in the room when there is no one there. Although you tell the client there is no one in the room he/she remains agitated and fearful.

4. Hallucinations - images or sounds originate in the mind and have no relationship to reality. Example - Mr. Jackson may set and talk to someone who is not there or who is even dead. He thinks he sees and hears the person.

5. Paranoia - clients with paranoia have delusions of being persecuted and a false sense of self-importance. They think you are out to get them or you are going to hurt them. Psychiatric care is needed for these clients.

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6. Alzheimer's - it is a slow progressive condition that prevents the individual from recognizing familiar objects. Three to ten years after the onset of Alzheimer's, they become unable to reason, lose control of their body functions, and cannot care for their personal needs.

7. Parkinson - symptoms are progressive over many years. Symptoms are tremors of the hands, muscle rigidity, difficult and slow movement, and gradual behavioral changes.

8. Seizures

   a. Petite Mal - momentary loss of consciousness

   b. Jacksonian - one-sided loss of muscular control; usually due to injury

   c. Grand Mal - an aura may occur before the seizure. The person loses consciousness and becomes rigid. Arms and legs move uncontrollably.

VI. Summary and Conclusion

A. Terms and definitions

B. The nervous system as a communication network

C. Neurons

D. Divisions of the nervous system

E. Conditions and changes of the nervous system

The nervous system keeps the body coordinated and plays an important part in the sensory system which will be covered in the next unit.

LESSON PLAN: 54

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XI : THE NERVOUS SYSTEM

INTERACTION ITEMS:

1. **What are the definitions of terms in this lesson?**
2. **What are the qualities necessary for the nervous system to act as a communication network?**
3. **What is the structure of a neuron?**
4. **What are the three types of neurons?**
5. **What are the three divisions of the nervous system?**
6. **Where are the areas of the brain located on HO 2, brain?**
7. **What are the functions of the cerebellum, cerebrum, thalamus, hypothalamus, brain stem, and spinal cord?**
8. **How many cranial nerves are there? How many spinal nerves?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Examine anatomical model of the brain.**
2. **Have an EEG technician speak to the class.**
3. **View slide tape series.**

ANSWERS TO EVALUATION ITEMS:

1. c
2. d
3. f
4. e
5. a

6. a. It is able to receive stimuli.
   b. It can respond by producing nerve impulses.
   c. It can conduct and coordinate neural information to and from the brain and spinal cord.

7. c
8. Axon

9. Central
   Peripheral
   Autonomic

10. a. Cerebrum
    b. Cerebellum
    c. Spinal cord
    d. Medulla
    e. Pons

11. e
12. d
13. a
14. c
15. b
16. 12
    31

17. Sympathetic
    Parasympathetic

18. c
19. d
20. b
21. a

LESSON PLAN: 54

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XI : THE NERVOUS SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

		Column I		Column II
____	1.	Conductivity	a.	Reacts when stimulated
____	2.	Fissure	b.	Matter which contains naked nerve fibers
____	3.	Axon	c.	Ability to transmit to distant points
____	4.	Dendrites	d.	Deep grove of a structure
____	5.	Irritability	e.	A process of the nerve cell that carries impulses toward the cell body
			f.	Structure of a nerve cell which carries impulses away from the cell body to the dendrites

6. List the three qualities which enable the nervous system to act as a communication network.

   a.

   b.

   c.

7. A neuron structure consists of the cell body, synapse, dendrites, and ____________________.

8. What are the three types of neurons (nerve cells)? (Circle the letter of the best answer.)

   a. Stem, lobe, thalamus
   b. Matter, conductivity, cortex
   c. Sensory, motor, connecting
   d. Reflex, pons, cord

9. Name the three divisions of the nervous system.

a.

b.

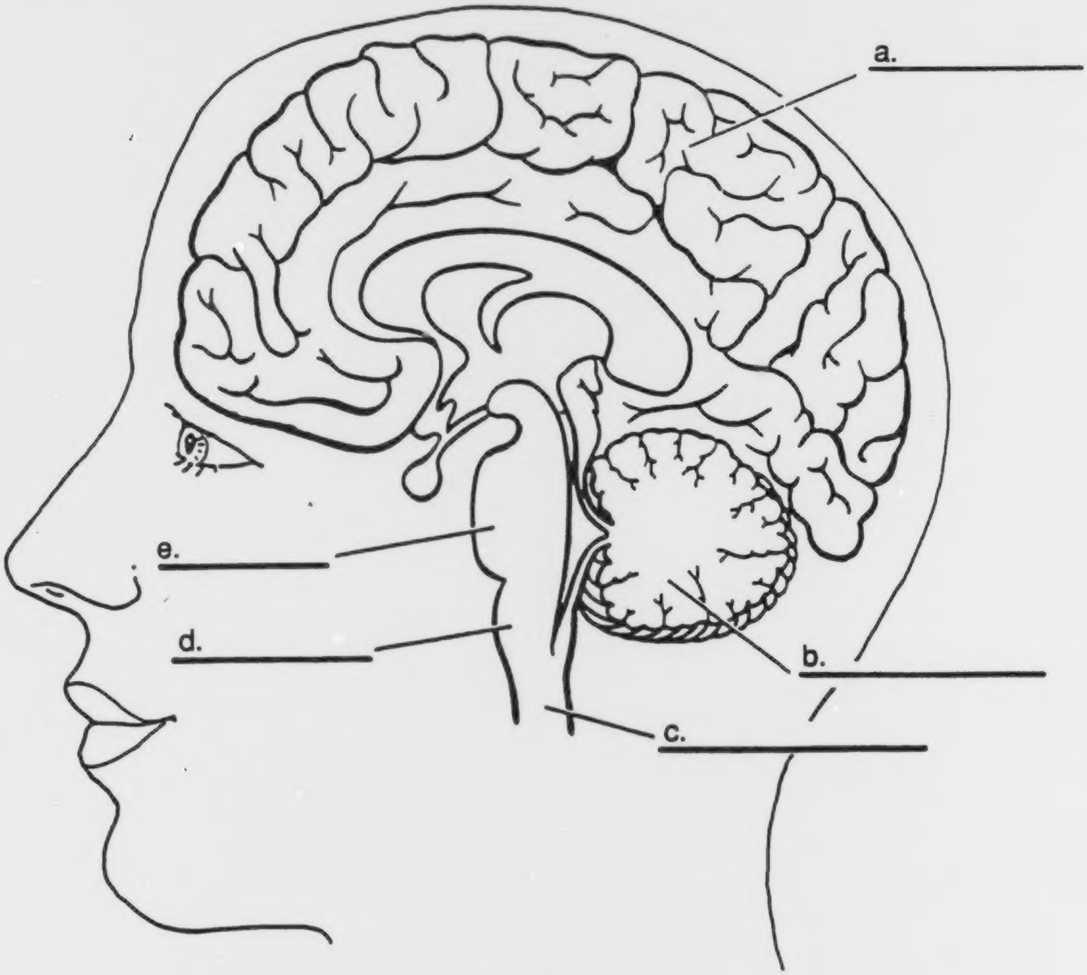
c.

10. Identify the parts of the brain.

a. ____________________ b. ____________________

c. ____________________ d. ____________________

e. ____________________



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Match the divisions of the brain in Column I with their functions in Column II.

Column I

___ 11. Thalamus

___ 12. Cerebrum

___ 13. Hypothalamus

___ 14. Cerebellum

___ 15. Brain stem

Column II

a. Regulates parasympathetic and sympathetic systems

b. Passageway for nerve impulses between the brain and spinal cord

c. Maintain body balance and muscle control

d. Controls motor functions, eye sight, hearing, and smell

e. A relay station for incoming and outgoing impulses

16. The number of nerves in the peripheral nervous system are cranial nerves ________________ pairs and spinal nerves ____________________ pairs.

17. The autonomic nervous system is made up of two divisions, the ____________________ and ______________________.

Match the conditions and changes in the nervous system in Column I to the correct definitions in Column II.

Column I

___18. Hallucination

___19. Petite Mal seizure

___20. Paranoia

___21. Alzheimer's

Column II

a. A slow, progressive condition that prevents the individual from recognizing familiar objects

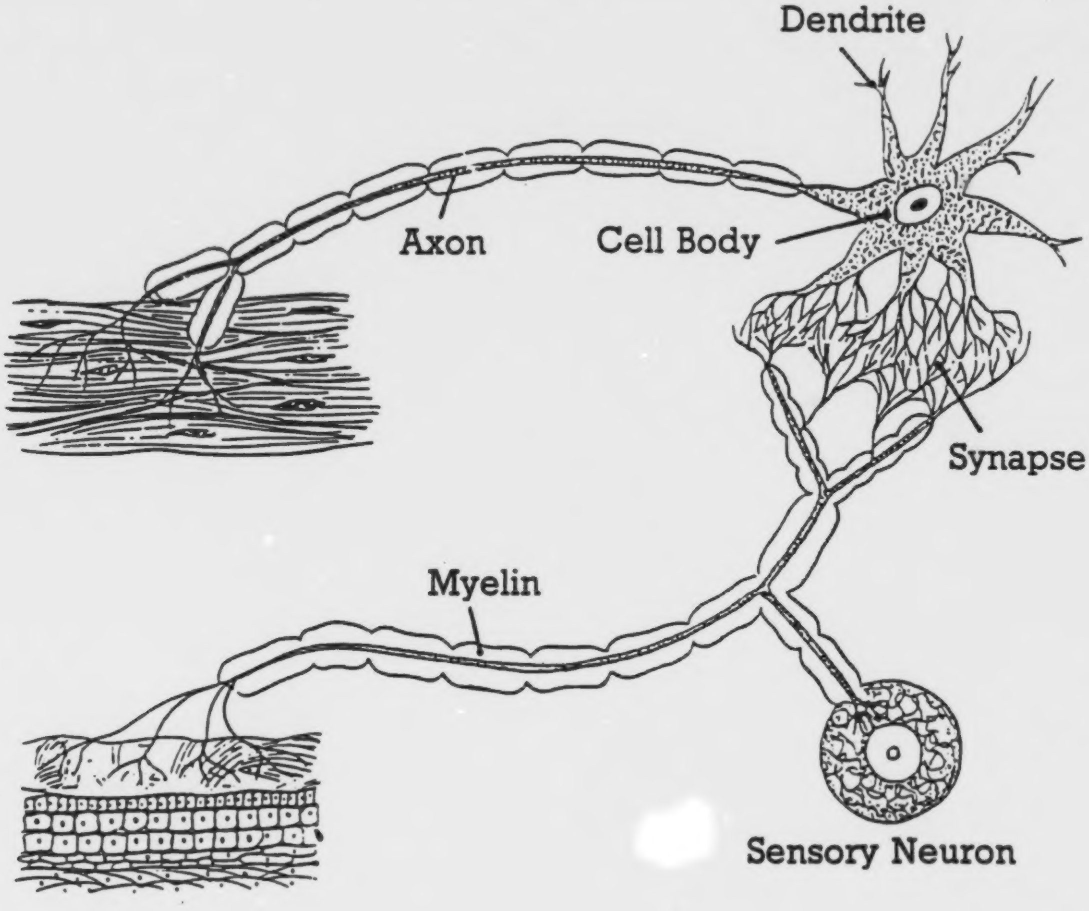
b. The individual has delusions of being persecuted and a false sense of self-importance

c. Images or sounds that originate in the mind and have no relationship to reality

d. Momentary loss of consciousness

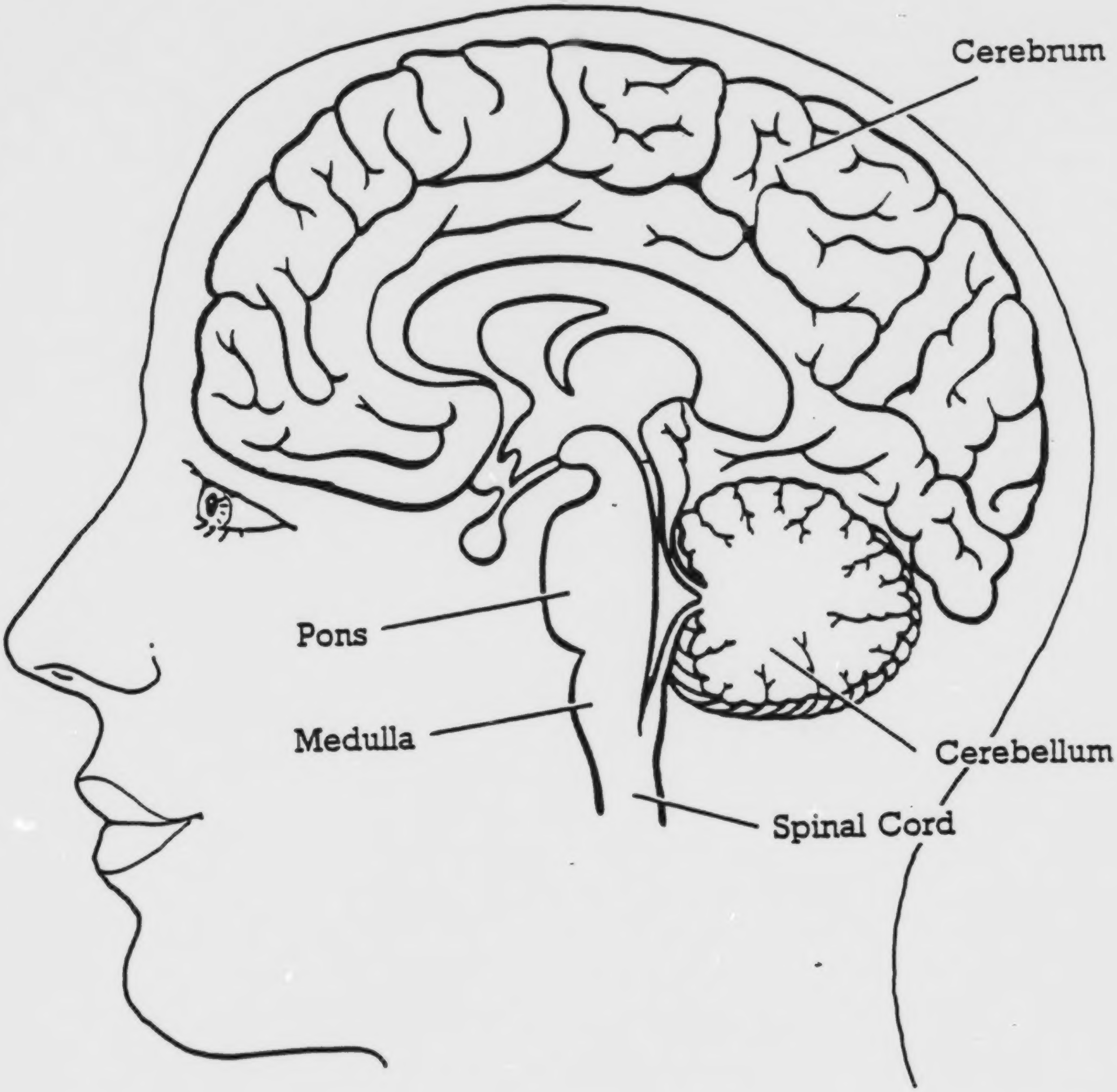
e. One-sided loss of muscular control

NEURON


Dendrite
Axon
Cell Body
Synapse
Myelin
Sensory Neuron

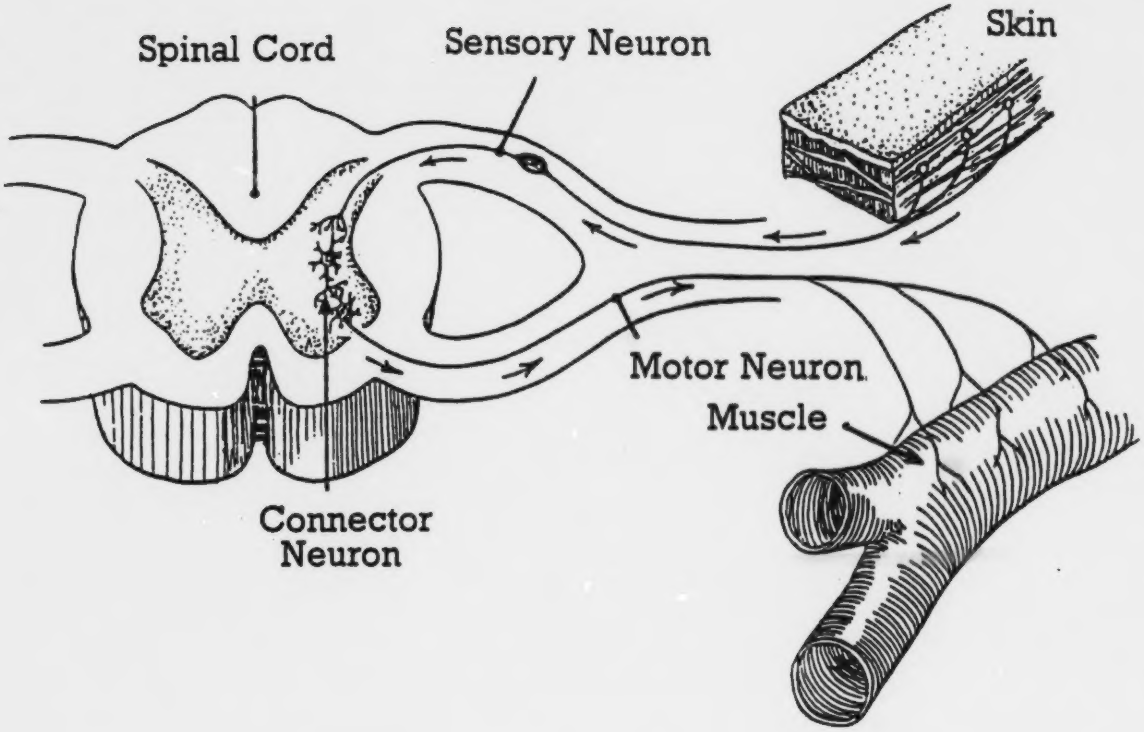
1030

THE BRAIN

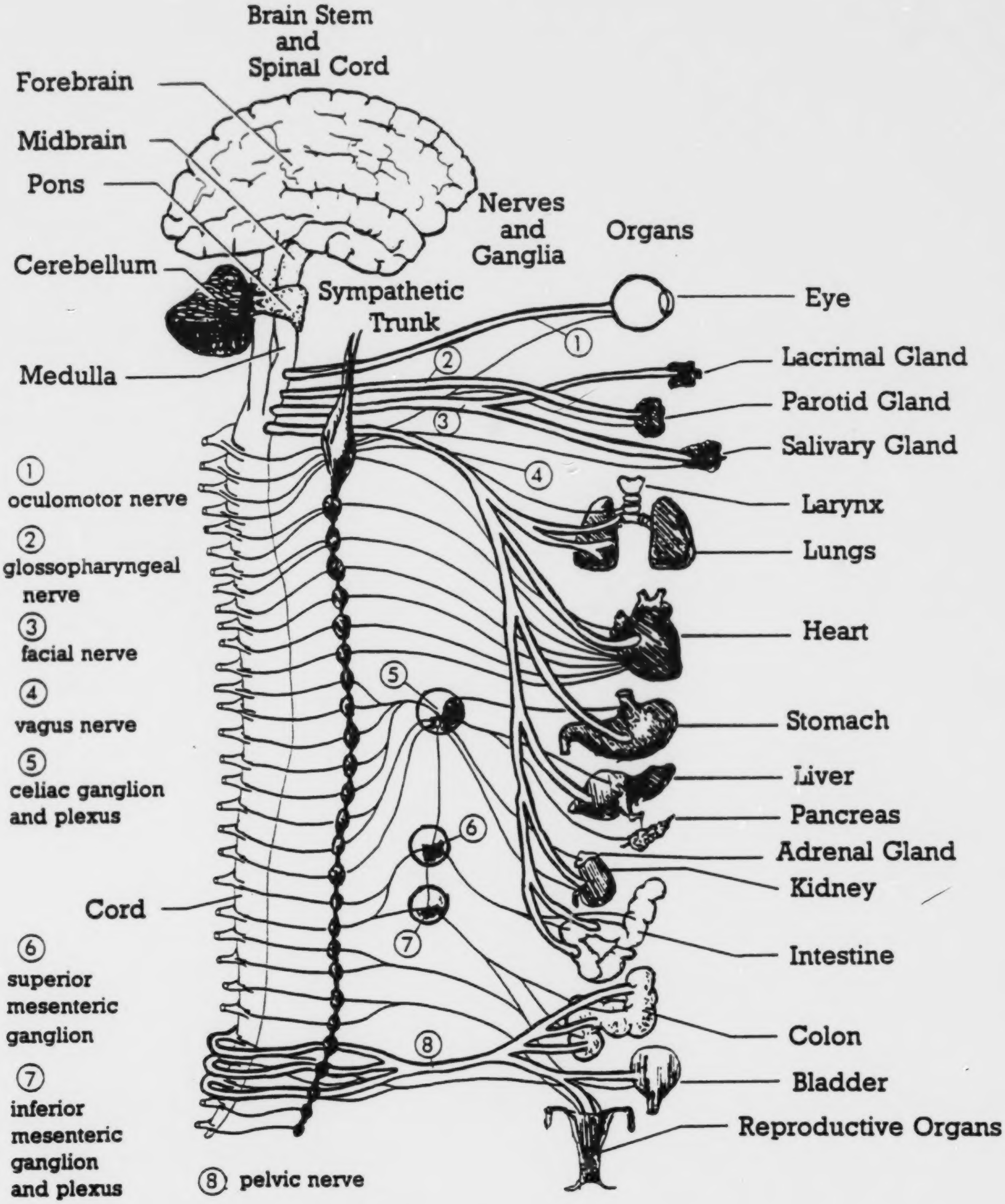

Cerebrum
Pons
Medulla
Cerebellum
Spinal Cord

1061

REFLEX ARC


Spinal Cord
Sensory Neuron
Skin
Motor Neuron
Muscle
Connector Neuron

THE NERVOUS SYSTEM


Brain Stem and Spinal Cord
Forebrain
Midbrain
Pons
Cerebellum
Medulla
Nerves and Ganglia
Organs
Sympathetic Trunk
Eye
Lacrimal Gland
Parotid Gland
Salivary Gland
Larynx
Lungs
Heart
Stomach
Liver
Pancreas
Adrenal Gland
Kidney
Intestine
Colon
Bladder
Reproductive Organs
Cord
① oculomotor nerve
② glossopharyngeal nerve
③ facial nerve
④ vagus nerve
⑤ celiac ganglion and plexus
⑥ superior mesenteric ganglion
⑦ inferior mesenteric ganglion and plexus
⑧ pelvic nerve

LESSON PLAN: 55

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XII : THE SENSORY SYSTEM

SCOPE OF UNIT:

The structure and function of the sensory system are examined. The medical terms and definitions and disorders and conditions pertaining to sensory system are included.

INFORMATION TOPIC: XII-55 OR DEMONSTRATION:

THE SENSORY SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms to their correct definitions.
2. Name the three components of the sensory mechanism.
3. List the five sense receptors and identify where they are located.
4. Label the parts of the eye.
5. Label the parts of the ear.
6. Match disorders and conditions of the eye and ear with the correct description.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Sensory System - Organs of Taste and Smell
2. HO 2: Eye Structure - The Organ of Sight
3. HO 3: Ear Structure - The Organ of Hearing
4. Anatomy charts
5. Anatomical model
6. State Fair Community College Media Center
    a. Slide/tape HO-80-590: Layers and Cavities of the Eye
    b. Slide/tape HO-80-592: Physiology of Vision

c. Slide/tape HO-80-593: External and Middle Ear
d. Slide/tape HO-80-594: Anatomy and Physiology of the External and Middle Ear

INFORMATIONAL ASSIGNMENT:

Real Lesson Plan 55 (Student Reference page 861) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

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INTRODUCTION:

Through the actions of the sense organs, people are made aware of themselves and the world around them. In this unit, we will see how a stimulus affects a nerve structure and the processes involved. We will pay particular attention to the eye and the ear.

NOTE: For care of eye glasses, refer to Personal Care, Lesson Plan 20.

LESSON PLAN: 55

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XII: THE SENSORY SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

  A. Opaque - cloudy; light is unable to pass through

  B. Visual acuity - the relative ability of the eye to see details clearly

  C. Ankylosis - complete immobility of bones

  D. Analgesic - pertaining to the giving of a medicine to remove or relieve pain

  E. Iritis - inflammation of the iris

  F. Nasal - pertaining to the nose

  G. Nasoscope - a lighted instrument to examine the nose

  H. Nasoseptal - pertaining to the nasal septum

  I. Ophthalmology - study or science of what is known of the eye and its structure

  J. Ophthalmoscope - an instrument to examine the eye

  K. Otalgia - earache or ear pain

  L. Otitis - inflammation of the ear

  M. Otologist - specialist in treating ear disorders

II. Components of a Sensory Mechanism (II-2)

  A. Receptor - special sense organs are stimulated.

  B. Nerve route - impulses travel along nerve pathway to brain.

  C. Centers in brain - sensations take place in the brain and are mentally referred back to the sense organ. (II-3)

III. Classifications of Sensory Receptors (HO 1)

  A. Taste receptors - located in mouth

B. Smell receptors - located in nose

C. Vision receptors - located in eyes

D. Hearing and equilibrium receptors - located in ears

E. Touch, pressure, and pain receptors - located in skin

IV. Eye Structure (HO 2) **(II-4)**

A. Three layers or coats of the eye

1. Sclera - outer layer; white of the eye

2. Cornea - window of the eye; located very front center of the sclera coat; transparent coat which allows light rays to pass through it

3. Choroid coat - middle layer

a. Iris - muscular layer; colored part of eye

b. Pupil - circular opening in choroid coat

c. Ciliary body - also located on the front part of the middle choroid coat

B. Lens - lies directly behind the pupil

C. Retina - innermost coat of the eyeball; contains receptors called rods for night vision and receptors called cones for day vision

D. Optic nerve

E. Accessory structures

1. Conjunctiva - lining of the inner surface of the eye lids

2. Lacrimal ducts - tear ducts

3. Eye muscles

4. Cavities in the eye

a. Anterior

b. Posterior

F. Eye fluid

1. Aqueous humor - fluid in front of the lens

2. Vitreous humor - jelly-like fluid behind the lens (II-5)

V. Ear Structure (HO 3)

   A. External

      1. Auricle

      2. External auditory meatus

   B. Middle - the cavity in the temporal bone

      1. Ear drum - tympanic membrane

      2. Ossicles - 3 small bones; transmit sound waves from the ear drum to the inner ear

         a. Malleus (hammer)

         b. Incus (anvil)

         c. Stapes (stirrup)

      3. Eustachian tube - connects to the pharynx; function is to equalize air pressure in the middle ear with that of outside atmospheric pressure

   C. Inner

      1. Cochlea - spiral-shaped passage; special organ of hearing; contains the cochlear duct which is filled with fluid that vibrates when sound waves from the stirrup bone strikes against it

      2. Auditory nerve

      3. Semicircular canals - help to maintain balance

VI. Disorders and Conditions of Eye and Ear

   A. Disorders of the Eye

      1. Cataracts

         a. The lens of the eye becomes opaque and light rays cannot pass through it to reach the retina which results in a loss of vision.

         b. The condition develops slowly and can be corrected with surgery.

      2. Glaucoma

BEST COPY AVAILABLE

a. It is caused by improper balance of the aqueous humor in the anterior eye cavity.

b. Pressure builds up in the eye because the fluid does not drain properly.

c. Pressure against the lens causes damage to the retina and loss of side vision.

d. This is a very serious condition. If it is found early, it can be treated with medication, but if not detected early, blindness usually occurs.

e. Acute glaucoma has a rapid onset and must be reported to the charge nurse immediately. The client will complain of nausea and intense pain.

3. Blindness

a. A person is considered blind when visual acuity is 20/200 or less in the better eye.

b. A person is considered partially sighted when visual acuity is between 20/70 and 20/200.

c. Care of the blind client

(1) Always speak before touching the blind person.

(2) Remember, a seeing eye dog is a working dog - don't touch the dog.

(3) Orient the blind person to his/her surroundings.

(4) Don't change anything in the surroundings without telling him/her.

(5) Always place articles for personal needs such as water glass and urinal in the same place each day.

(6) Use the face of a clock to describe placement of food on a tray.

(7) When ambulating a blind person, don't grab his/her arm. Instead have the client place his/her hand on your arm.

4. Surgical enucleation - removal of the eye usually due to injury or cancer

B. Disorders of the ear

1. Deafness

        a. Conductive hearing loss - caused by disease or injury that interferes with the conduction of sound waves to the inner ear

        b. Sensorineural hearing loss - nerve deafness; results from the malfunction of the inner ear, the auditory nerve, or the auditory center in the brain

    2. Otosclerosis - results from bony ankylosis of the stapes, which interferes with the vibration of the stapes and the transmission of sound to the inner ear

    3. Otitis media - fluid forms in the middle ear; usually results from an obstruction of the eustachian tube; can be caused by infection, allergy, tumors, or sudden changes in altitude

VII. Summary and Conclusion

A. Components of a sensory mechanism

B. Classification of sensory receptors

C. Eye structure

D. Ear structure

E. Disorders of the eye and ear

The anatomy of the eye and ear and disorders and conditions of the eye and ear were discussed. The next unit is the endocrine system.

LESSON PLAN: 55

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XII : THE SENSORY SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms presented in this lesson?
2. What are the three components of a sensory mechanism?
3. Where are the sensory receptors located?
4. Where on the eye anatomy diagram is the location of the sclerotic coat, retina, choroid coat, fovea, vitreous humor, iris, optic nerve, cornea, blind spot, aqueous humor, pupil, and lens?
5. Where on the ear anatomy diagram is the location of the semicircular canals, ear bones, cochlea, ear drum, and eustachian tube?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Invite a speaker from an eye bank in to discuss corneal transplants.
2. Invite a speech therapist or audiologist to speak to the class.
3. Do vision testing with Snellen chart or eye machine if available.
4. Show suggested slide/tapes or films.

ANSWERS TO EVALUATION ITEMS:

1. c
2. a
3. b
4. e
5. d
6. a. Receptor
   b. Nerve route
   c. Centers in the brain

7. a. Touch - skin, finger tips, etc.
   b. Smell - nose
   c. Taste - tongue
   d. Vision - eye
   e. Hearing - ear

8. a. 1
b. 6
c. 2
d. 5
e. 7
f. 12
g. 4
h. 11
i. 3
j. 8
k. 10
l. 9

9. a. 2
b. 1
c. 3
d. 5
e. 4

10. d
11. e
12. b
13. a
14. c

LESSON PLAN: 55

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XII : THE SENSORY SYSTEM

EVALUATION ITEMS:

Match the term in Column I with its definition in Column II.

1. Analgesic
2. Ophthalmology
3. Otalgia
4. Otologist
5. Nasal

a. Study or science of what is known of the eye and its structure

b. Earache or ear pain

c. Pertaining to the giving of a medicine to remove or relieve pain

d. Pertaining to the nose

e. Specialist in treating ear disorders

6. The three components of the sensory mechanism are:

   a.

   b.

   c.

7. List the five sense receptors and identify where they are located.

   a.

   b.

   c.

   d.

   e.

8. Label the parts of the eye by placing the number that labels the eye part in the diagram in the blank next to the corresponding term.

___ a. Sclerotic coat

___ b. Retina

___ c. Choroid coat

___ d. Fovea

___ e. Vitreous humor

___ f. Iris

___ g. Optic nerve

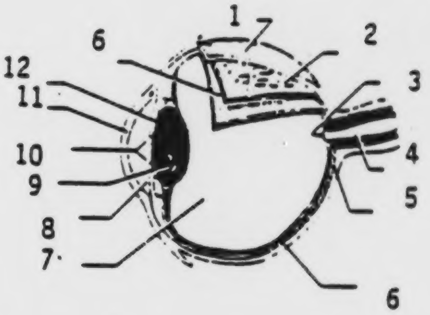
___ h. Cornea

___ i. Blind spot

___ j. Aqueous humor

___ k. Pupil

___ l. Lens



9. Label the parts of the ear by placing the number that labels the ear part in the diagram in the blank next to the corresponding term.

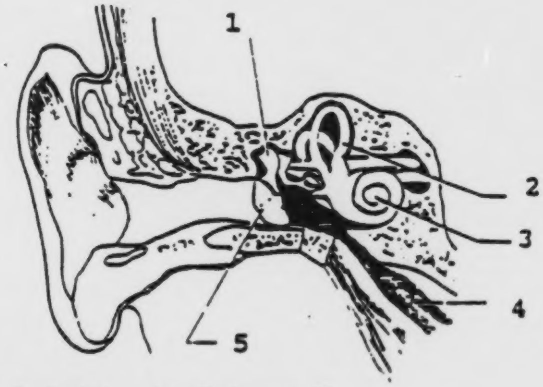
___ a. Semicircular canals

___ b. Ear bones

___ c. Cochlea

___ d. Ear drum

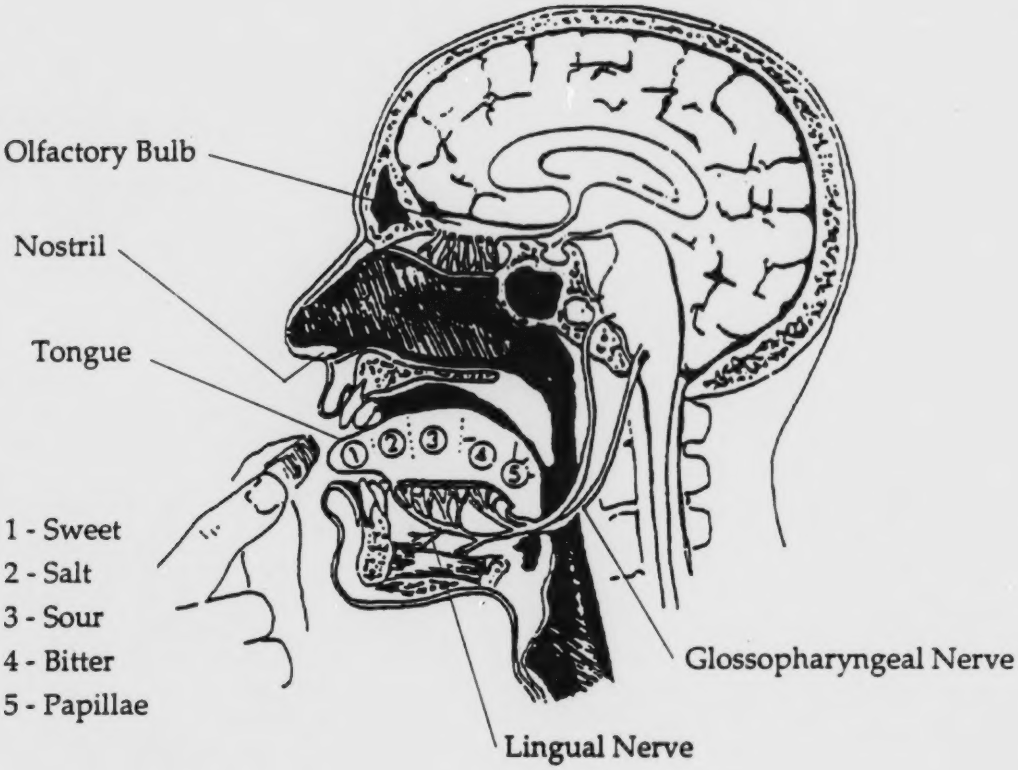
___ e. Eustachian tube



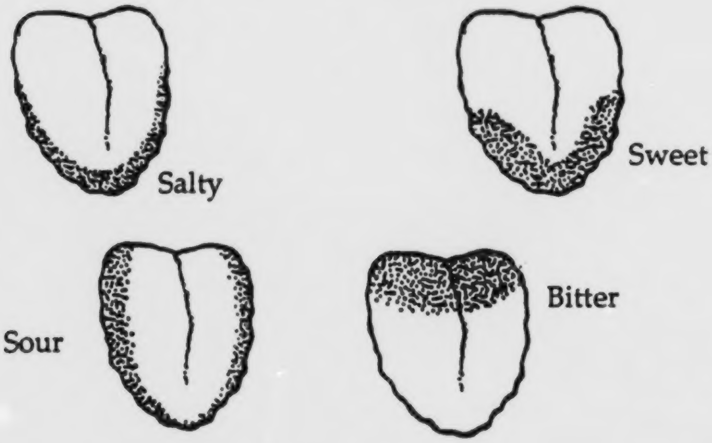
Match the terms in Column I with the correct definition in Column II.

	Column I		Column II
___ 10.	Otosclerosis	a.	Removal of the eyes
___ 11.	Glaucoma	b.	Formation of fluid in the middle ear
___ 12.	Otitis media	c.	Visual acuity is 20/200 or less in the better eye
___ 13.	Enucleation	d.	Bony ankylosis of the stapes
___ 14.	Blindness	e.	Pressure builds up in the eye because the fluid doesn't drain properly

THE SENSORY SYSTEM - ORGANS OF TASTE AND SMELL

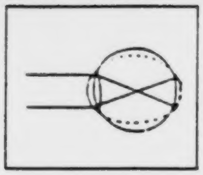

Olfactory Bulb
Nostril
Tongue
1 - Sweet
2 - Salt
3 - Sour
4 - Bitter
5 - Papillae
Glossopharyngeal Nerve
Lingual Nerve

TASTE LOCATIONS

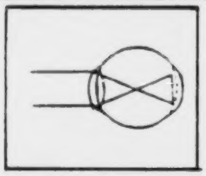

Salty
Sweet
Sour
Bitter

HO 2

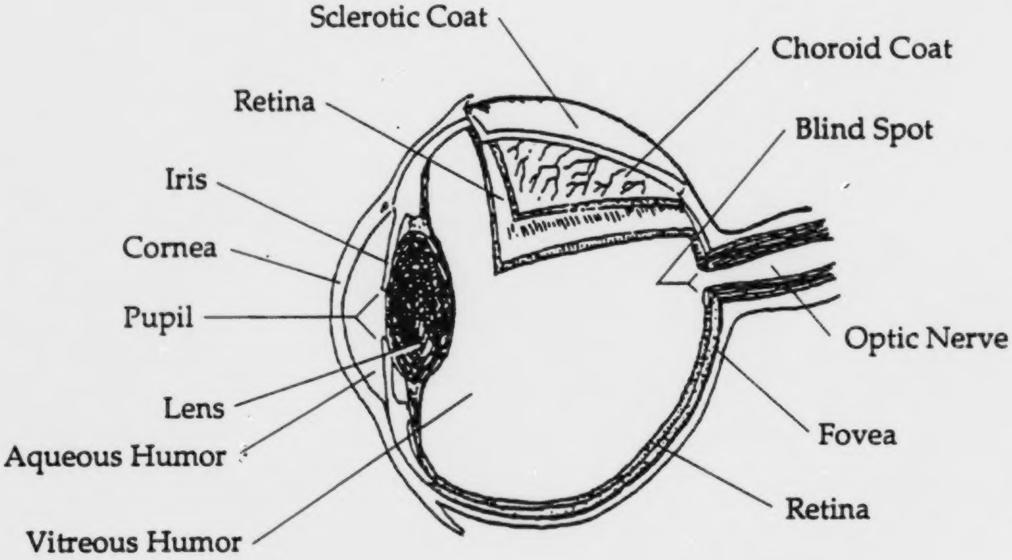
EYE STRUCTURE - THE ORGAN OF SIGHT

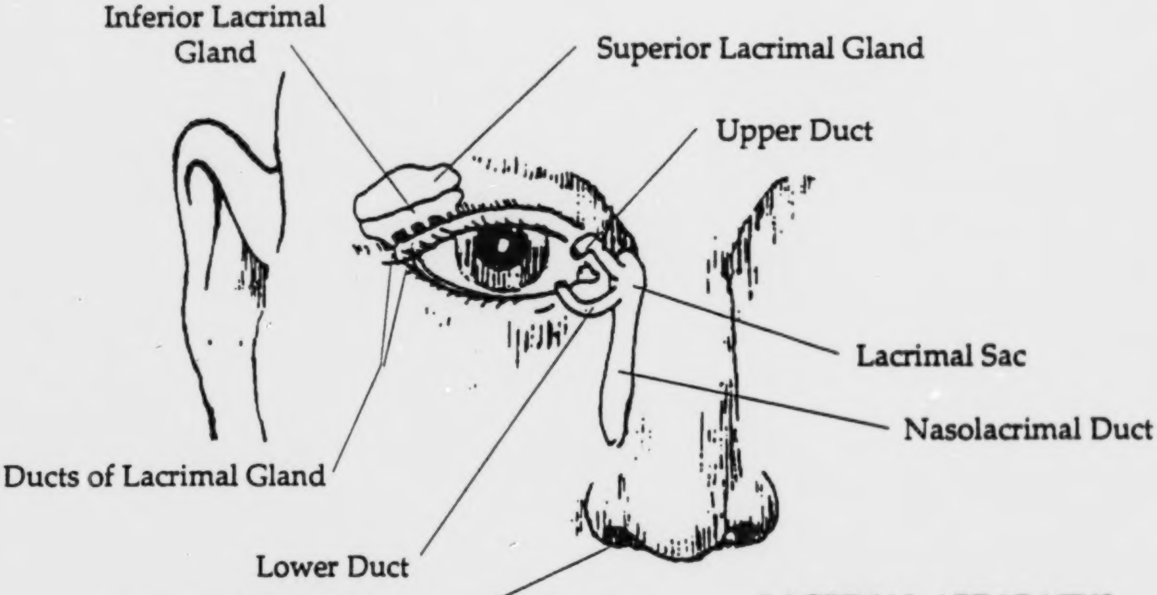


FAR SIGHTED



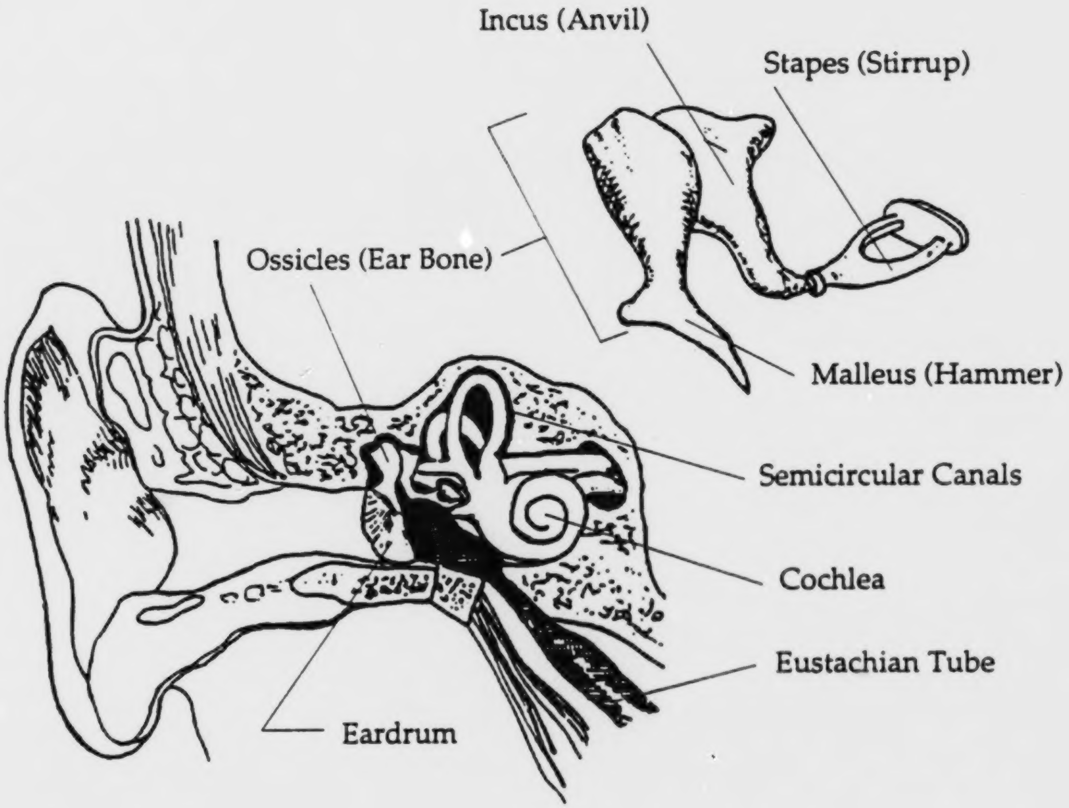
NEAR SIGHTED


Sclerotic Coat
Choroid Coat
Retina
Blind Spot
Iris
Cornea
Pupil
Optic Nerve
Lens
Fovea
Aqueous Humor
Retina
Vitreous Humor


Inferior Lacrimal Gland
Superior Lacrimal Gland
Upper Duct
Lacrimal Sac
Nasolacrimal Duct
Ducts of Lacrimal Gland
Lower Duct
Mouth of Duct (In Nose)

LACRIMAL APPARATUS

ANATOMY OF THE EAR


Incus (Anvil)
Stapes (Stirrup)
Ossicles (Ear Bone)
Malleus (Hammer)
Semicircular Canals
Cochlea
Eustachian Tube
Eardrum

LESSON PLAN: 56

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIII: THE ENDOCRINE SYSTEM

SCOPE OF UNIT:

The structure and function of the endocrine system are examined. Medical terms and definitions pertaining to the endocrine system are included.

INFORMATION TOPIC: XIII-56 OR DEMONSTRATION:

ENDOCRINE SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match the terms in this lesson with their correct definitions.
2. Locate and identify the glands of the endocrine system on a diagram.
3. Match the endocrine glands with their functions.
4. Match disorders and conditions of the endocrine system with the correct description or cause.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Endocrine System
2. HO 2: Diabetes
3. State Fair Community College Media Center slide/tape HO-80-600: Glands and Hormones, An Overview
4. Projector

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 56 (Student Reference page 873) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

INTRODUCTION:

The endocrine system is composed of a group of ductless glands that secrete substances called hormones into the blood or tissue fluid. The function of the endocrine system is communication and control by hormones. These hormones regulate our body processes. All of the organs of the endocrine system are glands, but not all glands are organs of the endocrine system.

LESSON PLAN: 56

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIII : THE ENDOCRINE SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

   A. Gland - any organ that produces a secretion

   B. Endocrine gland - an organized group of tissues that use materials from the blood or lymph to produce hormones

   C. Ductless gland - a gland that secretes hormones directly into the blood stream; (an endocrine gland)

   D. Exocrine or duct gland - a gland that discharges its secretions into ducts; are not endocrine glands

   E. Hormones - protein substance secreted by endocrine glands directly into the blood stream; circulated to another part of the body where it stimulates increased activity by chemical action

   F. Secrete - to produce and expel a special substance

   G. Pancreatectomy - surgical removal of the pancreas

   H. Pancreatic - pertaining to the pancreas

   I. Pancreatitis - inflammation of the pancreas

   J. Thyrocele - a tumor of the thyroid gland; a goiter

   K. Thyropenia - decreased or deficient activity of the thyroid

II. Glands of the Endocrine System (HO 1) **(II-2, 3)**

   A. Pituitary gland - the master gland

      1. Size of a pea

      2. Located deep in the cranial cavity in the small depression of the sphenoid bone; attached to the hypothalamus

      3. Has two lobes

         a. Posterior lobe

(1) Does not produce any hormones

(2) Stores the antidiuretic hormone and oxytocin (promotes milk ejection and causes the muscles of the uterus to contract) which are produced by the hypothalamus gland

b. Anterior lobe - secretions

(1) Thyroid stimulating hormone - stimulates growth and secretion of the thyroid gland

(2) Adrenocorticotrophic hormone - stimulates growth and secretion of the adrenal cortex

(3) Follicle stimulating hormone - controls growth of ovarian follicle and secretion of estrogen in female and production of sperm in male

(4) Interstitial cell - stimulates the secretion of testosterone in males

(5) Lactogenic hormone - stimulates the secretion of milk and is responsible for maternal behavior in females

(6) Growth hormone - responsible for the body's growth

B. Pineal gland

1. It is located in the skull beneath the brain.

2. The exact function of this gland is unknown; but is thought to regulate sexual development.

3. It gets smaller as we age.

C. Thyroid glands

1. Located in the neck, just in front of the larynx by the Adam's apple; shaped like a butterfly

2. Secretes

a. Thyroxin (thyroid hormone) - helps to regulate the metabolic rate of the body. In other words it is responsible for the release of energy for food to our cells and energy production.

b. Calcitonin - controls calcium concentration in the blood; it decreases calcium absorption from bone into the blood.

D. Parathyroid glands

  1. Four tiny glands embedded in the back of the thyroid gland

  2. Secrete parathyroid hormone - controls the use of calcium and phosphorus in the body; increases calcium absorption from bone into the blood

E. Thymus gland

  1. It is an endocrine gland and an organ of the lymphatic system.

  2. It is located anterior and superior to the heart and under the sternum.

  3. It begins to disappear at puberty.

  4. It secretes thymosin which develops and aids in the functioning of the body's immune system.

F. Adrenal gland

  1. An adrenal gland is located on top of each kidney (a total of two adrenal glands).

  2. Parts of each endocrine gland

    a. Adrenal cortex is the outer part. Adrenal cortex secretes three groups of corticoids.

      (1) Glucocorticoids

        (a) Helps maintain normal glucose concentration

        (b) Helps maintain normal blood pressure

        (c) Has an anti-inflammatory effect

        (d) Has an anti-immunity and anti-allergy effect

        (e) Helps control stress

      (2) Mineralocorticoid - helps control the amount of certain mineral salts in the blood

      (3) Androgens - responsible for male characteristics

    b. Medulla - inner part

      (1) Secretes epinephrine and norepinephrine

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(2) Function is to very quickly act to stress responses and help our bodies resist stress. (fight or flight)

G. Islands of Langerhans

1. Very small cells are scattered throughout the pancreas.

2. There are two types of cells in the islands of Langerhans.

   a. Alpha cells - secretes glucagon which increases the level of glucose in the blood stream

   b. Beta cells - produce insulin which helps to maintain a normal blood glucose level

H. Gonads - sex glands

1. Male - testes

   a. Produce testosterone

   b. Responsible for male characteristics

2. Female - ovaries; when stimulated by the pituitary gland, they secrete progesterone and estrogen.

   a. Progesterone - helps to maintain pregnancy

   b. Estrogen - responsible for female characteristics

III. Disorders and Conditions of the Endocrine System (II-4)

A. Diabetes mellitus - the body is unable to utilize glucose to meet the energy needs of the body. There is decreased secretion of insulin and this creates a disturbance of carbohydrate metabolism. (HO 2)

B. Hypothyroidism - there is insufficient secretion of thyroxin from the thyroid gland.

C. Hyperthyroidism - the thyroid gland secretes an excessive amount of hormone.

D. Cushing's syndrome - it is caused by an overactive adrenal gland.

E. Addison's disease - it is caused by an underactive adrenal cortex.

F. Gigantism - it is caused by an overactive pituitary gland.

G. Dwarfism - it is due to an underactive pituitary gland.

H. Cretinism - due to underactive thyroid gland; characterized by retarded physical and mental growth.

IV. Summary and Conclusion

A. Terms and definitions

B. Glands of the endocrine system

C. Disorders and conditions of the endocrine system

In this lesson we have discussed the glands of the endocrine system and how they are related to the disorders and conditions of the endocrine system. The next unit is the urinary system.

LESSON PLAN: 56

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIII: THE ENDOCRINE SYSTEM

INTERACTION ITEMS:

1. **What are the definitions of terms used in this lesson?**
2. **Where are the endocrine glands located?**
3. **What is a major function of each endocrine gland?**
4. **What are the causes of disorders and conditions of the endocrine system discussed in this lesson?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Assign short reports on abnormalities of endocrine system (dwarfism, gigantism, etc.).**

ANSWERS TO EVALUATION ITEMS:

1. b
2. e
3. f
4. a
5. c
6. a. Pituitary
   b. Thyroid
   c. Parathyroid
   d. Thymus
   e. Adrenal
   f. Pancreas
   g. Ovaries
   h. Testes
7. e
8. d
9. a
10. c
11. g
12. f
13. b
14. c
15. d
16. b
17. e
18. a

LESSON PLAN: 56

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIII : THE ENDOCRINE SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

Column I

____ 1. Ductless gland

____ 2. Exocrine gland

____ 3. Secrete

____ 4. Gland

____ 5. Endocrine gland

Column II

a. Any organ that produces a secretion

b. A gland that secretes hormones directly into the blood stream

c. An organized group of tissues which use material from the blood or lymph to produce hormones

d. Master gland of the body

e. A gland that discharges its secretions into ducts

f. To produce and expel a special substance

6. Identify the glands of the endocrine system indicated on the diagram.

a.

b.

c.

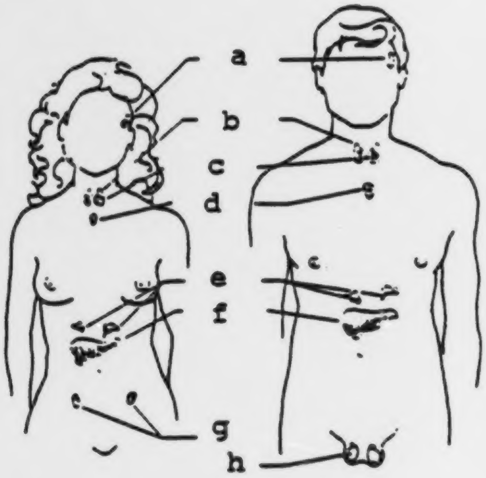
d.

e.

f.

g.

h.



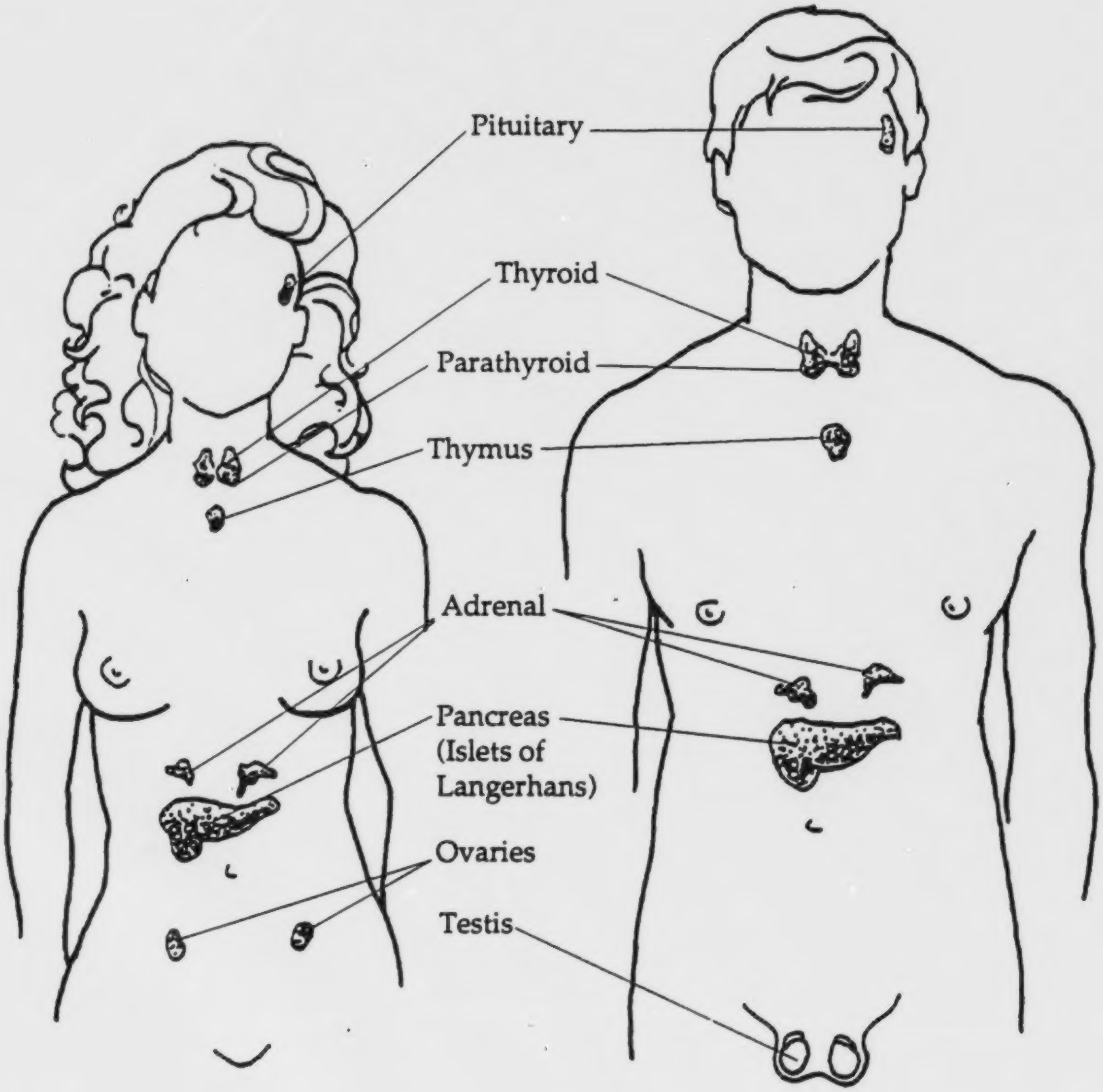
Match the gland in Column II to its function in Column I.

Column I	Column II
____ 7. Secrete insulin	a. Pituitary
____ 8. Secrete adrenalin	b. Thyroid
____ 9. Stimulate growth and development	c. Parathyroid
	d. Adrenal
____ 10. Regulate calcium and phosphorus	e. Pancreas
____ 11. Produce ovum	f. Testes
____ 12. Produce sperm	g. Ovaries
____ 13. Regulate metabolism	

Matching the terms in Column I to the correct definitions in Column II.

Column I	Column II
____ 14. Addison's disease	a. Characterized by retarded and mental growth
____ 15. Dwarfism	b. Caused by an overactive adrenal gland
____ 16. Cushing's syndrome	c. Caused by an underactive adrenal cortex
____ 17. Hyperthyroidism	d. Due to underactive pituitary gland
____ 18. Cretinism	e. The thyroid gland excretes an excessive amount of hormone

ENDOCRINE SYSTEM


Pituitary
Thyroid
Parathyroid
Thymus
Adrenal
Pancreas
(Islets of
Langerhans)
Ovaries
Testis

DIABETES

I. Description - Diabetes mellitus is a chronic metabolic disease. The body does not secrete enough insulin and the body is unable to utilize foods properly for energy. Diabetes Mellitus can develop at any age but is more frequent at age 40 or over.

II. Types (classification system was changed in 1979)

  A. Type I - The client is insulin dependent.

  B. Type II - The client is non-insulin dependent.

III. Cause - The cause is unknown, but individuals with a family history of diabetes and individuals who are overweight are at risk of developing diabetes.

IV. Signs and symptoms

  A. Fatigue (tired)

  B. Weight loss without dieting

  C. Inflammation of the vaginal area (vaginitis)

  D. Lesions and sores which take a long time to heal

  E. Sugar in the urine (glycosuria)

  F. Frequent urination (polyuria)

  G. Excessive thirst (polydipsia)

  H. Impairment of vision

  I. Increased hunger (polyphagia)

V. Complications - hypoglycemia and hyperglycemia

  A. Hypoglycemia is low blood sugar. It can lead to insulin shock.

    1. Cause

      a. Not eating all of the food prescribed by the physician or missing a meal

      b. Too much activity for the amount of food eaten

      c. Taking too much insulin

    2. Symptoms (usually occur suddenly)

        a. Profuse perspiration, skin cold, clammy, pale
        b. Weak, dizzy, complains of feeling faint
        c. Hunger
        d. Nervous, irritable, excitable
        e. Shallow, rapid respirations
        f. Pulse may be normal or slow and bounding
        g. Vision blurred
        h. Glucose in urine and sugar in blood are low when tested.
    3. If the client is awake, the charge nurse may instruct you to give him/her some type of sugar, such as orange juice.

B. Hyperglycemia is high blood sugar. It can lead to diabetic coma.
    1. Cause
        a. Occurs when the client doesn't have enough insulin to meet the needs of his/her body
        b. The client forgets to take his/her insulin
        c. Medications
        d. Dehydration
        e. Injury
        f. Infection
    2. Symptoms (usually occur slowly)
        a. The first symptoms are usually that the client appears confused, appears very drowsy, or complains of a headache.
        b. There is a fruity odor to the breath.
        c. The skin is flushed and dry.
        d. Pulse is rapid and weak.
        e. Blood pressure is low.
        f. Nausea and vomiting
        g. Loss of appetite

        h. Respirations are deep, rapid, and labored.

        i. Loss of consciousness

    3. The treatment is administering insulin, which is done by the charge nurse

VI. Responsibilities of the health care assistant

  A. Know the symptoms of hyperglycemia and hypoglycemia.

  B. Know where orange juice, sugar, crackers, and milk are kept on the unit.

  C. Make certain the diabetic client has the correct meal tray.

  D. Note and report food the client ate or if he/she did not eat the food on meal tray. Notify the charge nurse if a client does not like a food on meal tray.

  E. Give daily foot care and report anything unusual to the charge nurse.

  F. Look for sores or injury to the skin and report to the charge nurse.

VII. Treatment

  A. Diet - the most important treatment to control the condition

    1. The diet is prescribed by a physician. When prescribing the diet, the physician considers the client's height, weight, age, sex, activity level, and dietary habits.

    2. Exchange list is used. A list of substitutions and exchanges are provided so that the diet can be varied.

  B. Insulin and oral hypoglycemia drugs are ordered by the physician if the condition cannot be controlled by diet.

Credits:

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 36.

Schniedman, Rose; Susan Lambert; Barbara Wander. Being a Nurse Assistant, 5th ed. Englewood Cliff, N.J.: Prentice Hall, 1989, Unit 35.

Sorrentino, Sheila A. Textbook for Nursing Assistants, 3rd ed. St. Louis, MO: Mosby-Year Book, Inc., 1992, Chapter 16.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 14.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 11.

LESSON PLAN: 57

COURSE TITLE: HEALTH-CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

SCOPE OF UNIT:

The structure and function of the urinary system are examined. The medical terms and definitions pertaining to the urinary system are included. In addition, this unit covers all aspects of the elimination of urine; bladder and bowel retraining; giving and removing a urinal; collection of routine and clean-catch/midstream urine specimens; collection of a urine specimen from a catheter; changing a urine bag; and peri care for a resident who has a catheter.

INFORMATION TOPIC: XIV-57 OR DEMONSTRATION:

URINARY SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms in this lesson with their correct definitions.
2. Identify the functions of the urinary system.
3. Label the organs of the urinary system.
4. Label the parts of the kidney.
5. Describe a nephron.
6. Identify the functions of the ureters.
7. Describe how urine leaves the bladder.
8. List the functions of the urethra.
9. Identify normal and abnormal substances in urine.
10. Identify disorders and conditions of the urinary system.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Urinary System

2. HO 2: Cross Section of a Kidney

3. HO 3: Nephron

4. Characteristics of Urine, slide/tape HO-R82-515, State Fair Community College Media Center

5. Projector

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 57 (Student Reference page 885) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed. St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.

INTRODUCTION:

In this unit we will study the structure and function of the urinary system. The study of the urinary system is called urology. A physician who specializes in this field is called a urologist. The function of the urinary system is to excrete the waste products of water, urine, and salts from the body.

LESSON PLAN: 57

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

A. Adipose capsule - a mass of fat tissue that encloses each kidney and its blood vessels

B. Renal fascia - a tough, fibrous tissue that covers the adipose capsule

C. Renal pelvis - funnel-shaped structure located at the upper end of each ureter

D. Anuria - diminution of urinary secretions to 100 cc or less in 24 hours

E. Glycosuria - sugar in the urine

F. Oliguria - diminution of urinary secretions to between 100 and 400 cc in 24 hours

G. Polyuria - excessive secretion of urine

H. Urinary retention - no urine is voided

I. Urinary suppression - kidneys do not produce any urine but the bladder retains the ability to empty

J. Renal colic - pain caused by passing a kidney stone

K. Dysuria - painful urination

L. Acetone - ketone bodies that appear in the urine

M. Ketone body - acids produced during fat catabolism

N. Micturition - voiding or urination

O. Albuminuria - presence of serum albumin in the urine

P. Hematuria - presence of blood in the urine

Q. Melanuria - black or dark discoloration of the urine

R. Nocturia - excessive urination at night

S. Pyelitis - inflammation of the pelvis of the kidney

T. Pyuria - the presence of pus in the urine

II. Functions of the Urinary System (II-2)

A. To produce urine

B. Eliminate urine from the body

III. Organs of the Urinary System (HO 1) (II-3)

A. Two kidneys

B. Two ureters

C. One bladder

D. One urethra

IV. Kidneys (HO 2) (II-4)

A. Location

1. The bean-shaped kidneys rest high against the dorsal wall of the abdominal cavity.

2. Put your hands on your hips with your thumbs above your hipbones. Your kidneys are located at the placement of your thumbs.

3. They lie on either side of the vertebral column and between the peritoneum and the back muscle.

4. They are between the 12th thoracic and the 3rd lumbar vertebrae.

5. The right kidney is lower than the left. This is due to the location of the liver.

B. Internal structure

1. Cortex

a. Outer part of kidney

b. Contains the renal corpuscles of the nephron units

2. Medulla - the inner portion of the kidney

3. Pyramids - triangular-shaped divisions of the medulla of the kidney

4. Papilla - innermost end of a pyramid

    5. Pelvis - expanded end of the upper part of the ureter

    6. Calyx - division of the renal pelvis

  C. Form urine by: filtration, reabsorption, and secretion

V. Nephron (HO 3) **(II-5)**

  A. Millions of structural units which make up the kidney

  B. Parts of a nephron

    1. Afferent arteriole - carries blood from the renal artery

    2. Bowman's capsule - top of the nephron; surrounds the glomerulus

    3. Glomerulus - network of blood capillaries tucked into the Bowman's capsule

    4. Renal tubule

      a. Proximal convoluted tubule - first part of the renal tubule

      b. Loop of Henle - extension of the proximal tubule

      c. Distal convoluted tubule - extension of loop of henle

      d. Collecting tubule - straight extension of distal tubule

VI. Ureters - There are two ureters, one from each kidney. Their function is to carry urine from the kidneys to the bladder. **(II-6)**

VII. Bladder **(II-7)**

  A. Located in the pelvis behind the pubic symphysis

  B. Stores approximately one pint of urine

  C. Urine leaves the bladder by way of the urethra and out the urinary meatus.

VIII. Urethra **(II-8)**

  A. Lowest part of urinary tract

  B. External opening is the meatus

  C. Female urethra - serves as passageway for urine; 1 1/2 inches long

  D. Male urethra - serves as passageway for urine and semen; 8 inches long

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IX. Urine

A. Normal findings - acid, 95 percent water, nitrogenous waste products (urea), excess minerals (sodium, potassium, calcium, etc.), toxins, hormones, yellow pigment (II-9)

B. Abnormal findings - blood, glucose, pus, casts, and albumin

X. Disorders and Conditions of the Urinary System (II-10)

A. Renal calculi - kidney stones

B. Uremia - renal failure; develops gradually due to changes in blood vessels which serve the kidney, or to aging or hypertension

C. Cystitis - inflammation of the bladder

D. Nephritis - inflammation of the kidney

XI. Summary and Conclusion

A. Terms and definitions

B. Functions of the urinary system

C. Organs of the urinary system

D. Kidneys

E. Nephron

F. Ureters

G. Bladder

H. Urethra

I. Urine

J. Disorders and conditions of the urinary system

This lesson has included terms and definitions pertaining to the urinary system and the structure and function of the organs of the urinary system. The next lesson will be on the elimination of urine.

LESSON PLAN: 57

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

INTERACTION ITEMS:

1. What is the definition of each term presented in this lesson?
2. What is the function of the urinary system.
3. Where are the kidneys, ureters, bladder, and urethra located?
4. Where are the medulla, renal pelvis, ureter, and cortex located in the kidney?
5. What is the nephron?
6. What is the function of the ureters?
7. How does urine leave the bladder?
8. What are the functions of the urethra?
9. What are normal findings in the urine?
10. How do you describe renal calculi, uremia, cystitis, and nephritis?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. If possible, visit a dialysis unit.
2. On an anatomical model, name and locate the organs of the urinary system.
3. Assign reports or panel discussions on diseases of the urinary system and/or progress made to help residents.

ANSWERS TO EVALUATION

1. c
2. e
3. f
4. a
5. h
6. d
7. b
8. d

9. a. Kidneys
b. Ureter
c. Bladder
d. Urethra

10. a. Medulla
b. Renal pelvis
c. Ureter
d. Cortex

11. Kidney
12. Ureters
13. Urethra
14. Meatus

15. a. A
b. N
c. N
d. A
e. N
f. A
g. N
h. A

16. c

LESSON PLAN: 57

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I

____ 1. Glycosuria

____ 2. Polyuria

____ 3. Urinary retention

____ 4. Renal colic

____ 5. Dysuria

____ 6. Hematuria

____ 7. Pyuria

Column II

a. Pain caused by passing a kidney stone

b. The presence of pus in the urine

c. Sugar in the urine

d. Blood in the urine

e. Excessive secretion of urine

f. No urine is voided

g. Kidneys do not produce any urine

h. Painful urination

8. The function of the urinary system is to: (Circle the letter of the best answer.)

   a. Inhale air and exchange body gases.
   b. To fight infection and produce antibodies.
   c. To serve as the framework for the body.
   d. To produce and eliminate urine.

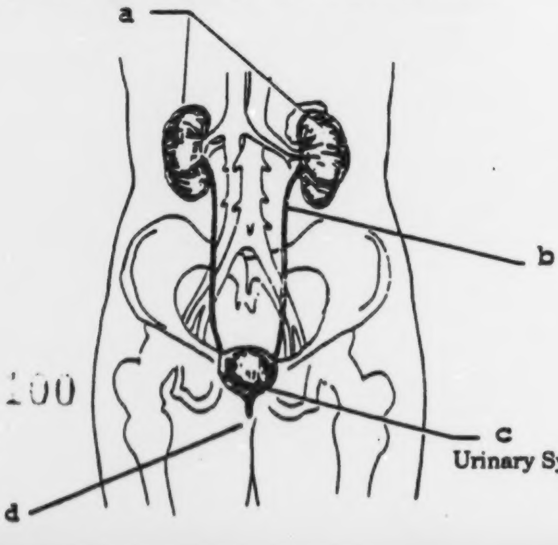
9. Label the parts of the urinary system indicated on the diagram below.

   a.

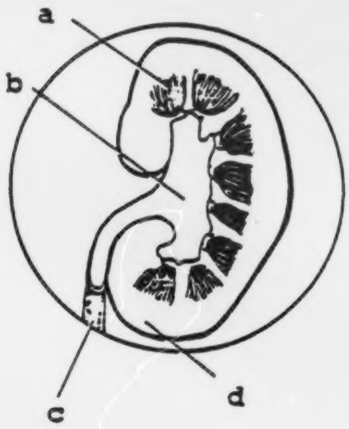
   b.

   c.

   d.



10. Label the parts of the kidney shown on the diagram.



a.

b.

c.

d.

11. Nephrons are millions of structural units which make up the ____________________________.

12. ____________________________ carry urine from the kidneys to the bladder.

13. Urine leaves the bladder by way of the ______________________________.

14. The external opening of the urethra is the ______________________________.

15. Write "A" before substances which are abnormal in urine. Write "N" before those substances which are normal constituents of urine.

____ a. Glucose

____ b. Water

____ c. Urea

____ d. Blood

____ e. Toxins

____ f. Pus

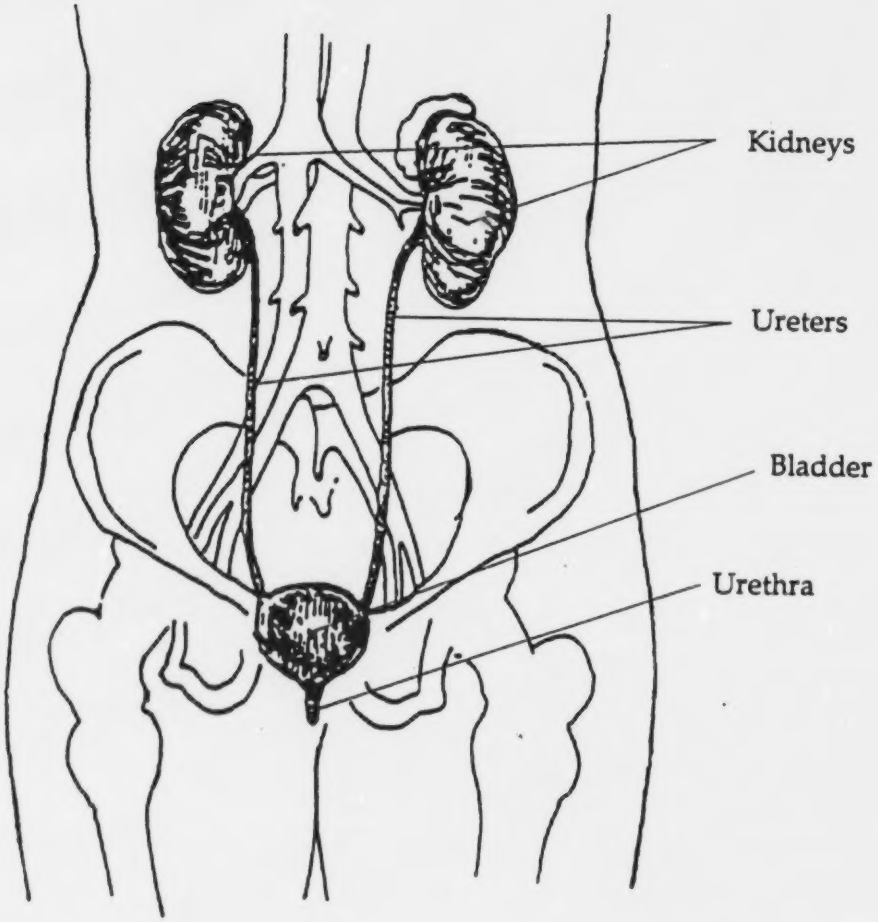
____ g. Salt

____ h. Albumin

16. Nephritis is defined as: (Circle the letter of the best answer.)

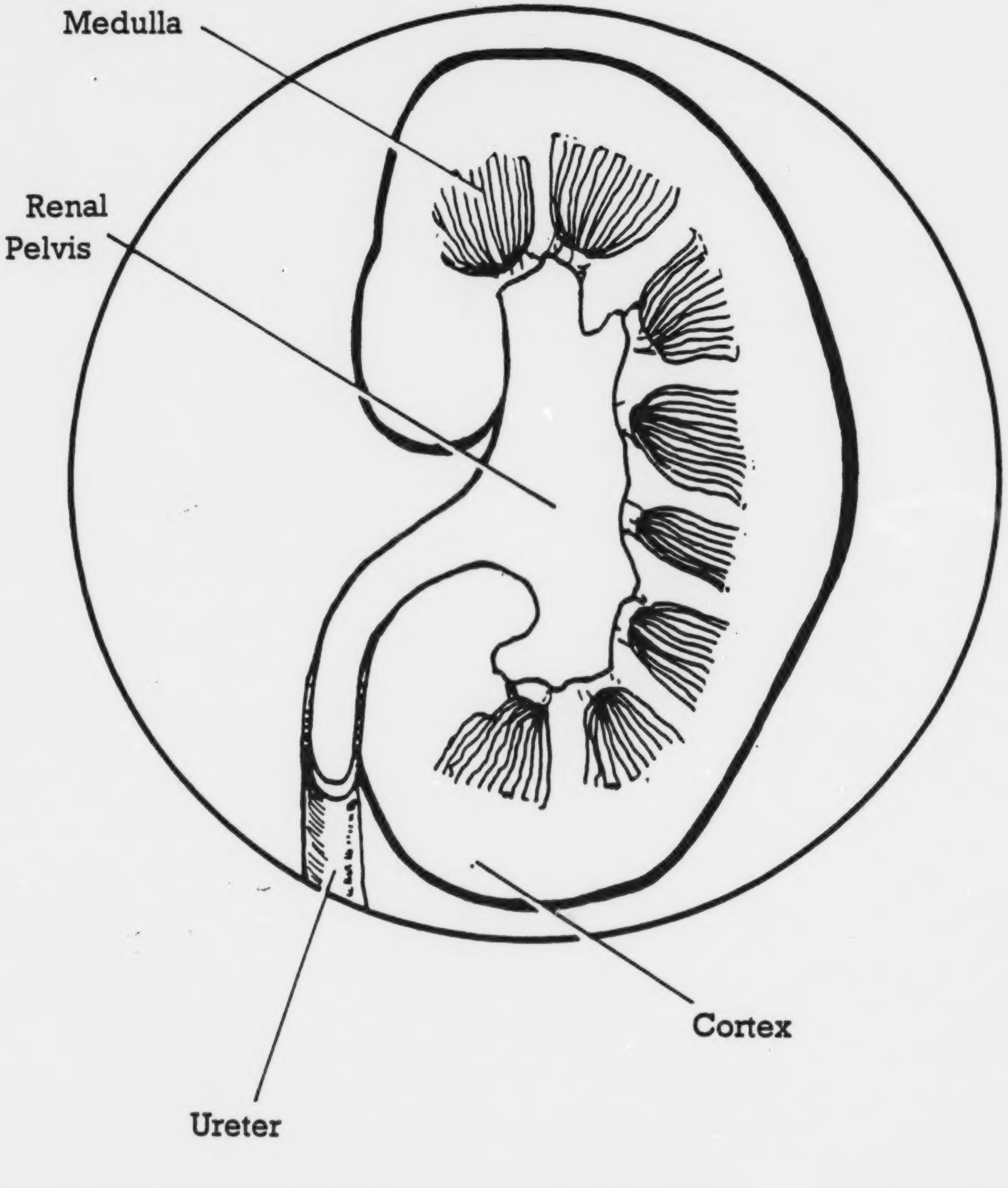
a. Kidney stones.
b. Renal failure.
c. Inflammation of the kidney.
d. Inflammation of the bladder.

THE URINARY SYSTEM

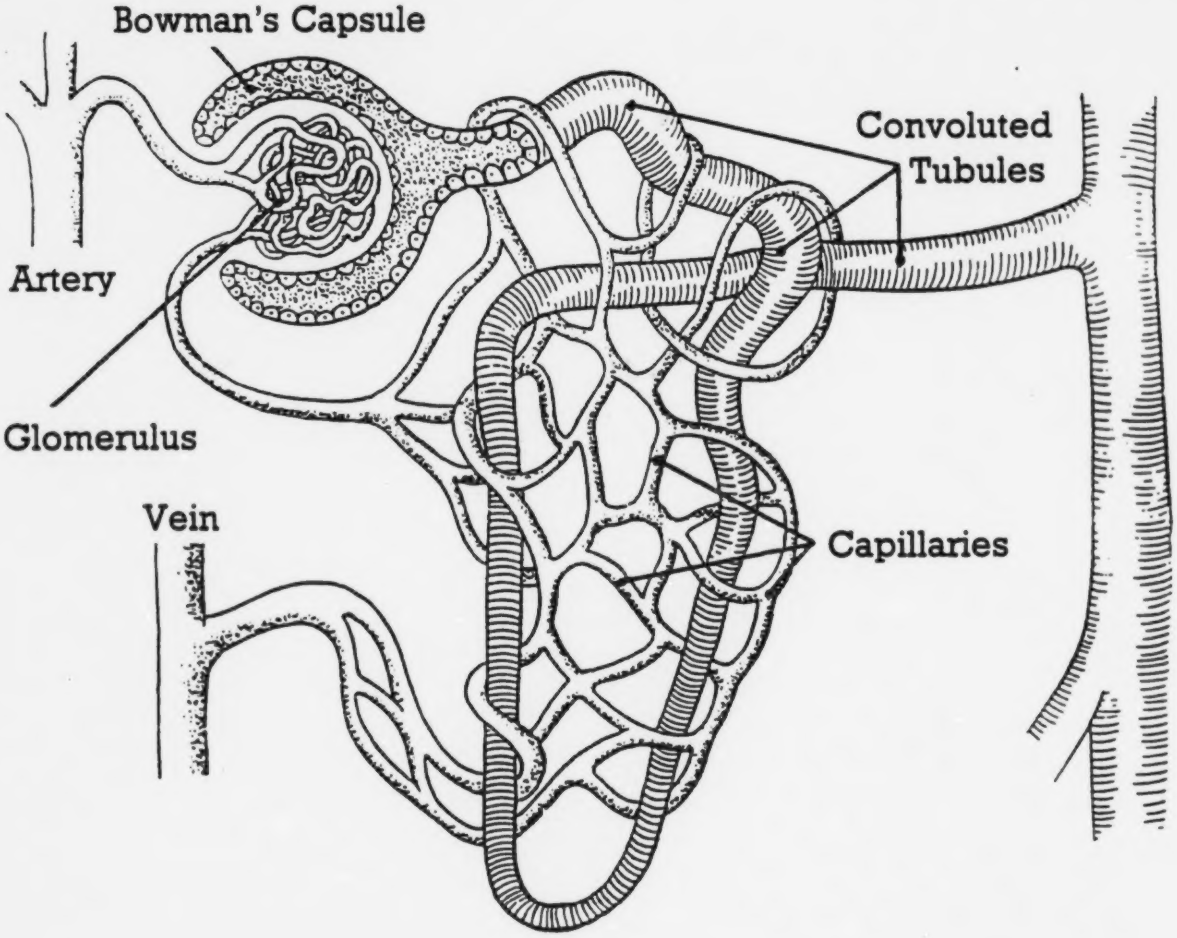

Kidneys
Ureters
Bladder
Urethra

1102

CROSS-SECTION OF A KIDNEY


Medulla
Renal Pelvis
Cortex
Ureter

NEPHRON


Bowman's Capsule
Convoluted
Tubules
Artery
Glomerulus
Vein
Capillaries

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV: THE URINARY SYSTEM

SCOPE OF UNIT:

The structure and function of the urinary system are examined. The medical terms and definitions pertaining to the urinary system are included. In addition, this unit covers all aspects of the elimination of urine; bladder and bowel retraining; giving and removing a urinal; collection of routine and clean-catch/midstream urine specimens; collection of a urine specimen from a catheter; changing a urine bag; and peri care for a client who has a catheter.

INFORMATION TOPIC: XIV-58 AND DEMONSTRATION: XIV-58

ELIMINATION OF URINE
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson to correct definitions.
2. Identify factors which maintain urine elimination.
3. Describe the characteristics of normal urine.
4. Identify conditions and symptoms that may cause abnormal urine elimination.
5. Identify factors that can lead to urinary incontinence.
6. List two special measures for abnormal urinary function.
7. Identify key points in giving and removing urinals and bedpans.
8. Identify responsibilities of the health care assistant when assisting client to the bathroom.

Demonstration

9. Give peri care with catheter according to the steps of procedure.
10. Change a drainage bag according to the steps of procedure.
11. Assist client in using urinal according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Catheters
2. HO 2: Urinal and Bedpans
3. Indwelling catheter
4. External catheter
5. Elimination, Specimen Collection and Urinary Care, video #5, available from the Missouri Vocational Resource Center, 34 min.
6. Television and VCR
7. Chase doll (if available)
8. Basin - 1/2 full of warm water
9. Washcloths
10. Mild soap
11. Disposable or reusable bed protector
12. Towels
13. Bath blanket
14. Urinal and cover
15. Bedpan and cover
16. Gloves
17. Specimen container
18. Specimen label

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 58 (Student Reference page 897) prior to class and be prepared to discuss the information presented and return the demonstrations on giving peri care with catheter care, changing a drainage bag, and assisting client in using a urinal.

REFERENCES:

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INTRODUCTION:

Elimination of urine is one of the body's basic functions. The elimination system must work properly to rid the body of wastes; if not, the client will become very ill. The health care assistant must be aware of the importance of proper fluid intake and the need to get all clients to the bedpan or toilet as often as necessary.

It is estimated that 40 to 60 percent of the clients in nursing homes are incontinent of urine. The older person does not deliberately become incontinent. One reason for incontinence is the decreased time between the sensation to void and the need to void. This means there is very little time to get to the bathroom after the client feels the need to void.

The client may become very embarrassed and upset when he/she is incontinent. The health care assistant can help prevent this by being considerate and by not blaming the client for not saying something sooner.

Clients who are unable to get out of bed to use a portable bedside commode or go to the bathroom toilet must use a urinal or bedpan. The urinal is a container in which the male client urinates; he must use a bedpan if he needs to defecate. The female client must use a bedpan for urination and defecation. Remember how important it is to keep this equipment clean to prevent the spread of infection, and that it is to be used only by the client to whom it belongs. Always empty urinals/bedpans into toilets--never into a sink. Urinals and bedpans should never be left sitting on the bedside stand.

NOTE: Assisting client in using the bedpan was covered in Elimination of Stool, Lesson Plan 37.

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

   A. Bladder - a muscular sac that stores the urine in the body

   B. Catheter - a sterile tube inserted into bladder to drain urine

   C. Incontinent - inability to control the passage of urine

   D. Kidneys - filtering system of the body

   E. Sphincter muscles - a circle of muscle fibers around the outlet of the urethra and rectum which are normally closed but can be relaxed to allow passage of urine and stool

   F. Ureters - tubes that carry urine from kidneys to urinary bladder

   G. Urethra - the small passage from the bladder through which urine leaves the body

   H. Urinate - to pass urine (void)

   I. Catheterization - the process of inserting a catheter

   J. Foley catheter - a catheter that is left in the urinary bladder so that urine drains continuously into a bag

   K. Retention catheter - a Foley or indwelling catheter

   L. Renal calculi - kidney stones

II. Factors Which Maintain Urine Elimination

   A. Fluids (II-2)

      1. The body needs an adequate intake of fluids for proper functioning of the urinary system.

      2. Nursing responsibilities (II-3)

         a. Ensure adequate intake of 2,000-3,000 cc of fluid per 24 hours (2-3 quarts).

        b. Most fluids should be given between 7 a.m. and 7 p.m. to prevent client from having to get up during the night to void. (II-4)

B. Habits/pattern

    1. The body usually eliminates urine every two to three hours if intake is adequate.

    2. Nursing responsibilities

        a. Find out where and how often the client usually voids.

        b. Try to follow established routine and respect privacy.

III. Normal Urine Characteristics (II-5)

A. Color - straw yellow

B. Clarity - clear, free of sediment and mucus

C. Amount - usual amount voided is 200-300 cc five to six times a day or 1,000 to 1,500 cc every 24 hours

D. Odor - none, except with certain liquids such as coffee

E. Frequency - depends on fluid intake, most people void at least every three hours

IV. Conditions That May Cause Abnormal Urine Elimination (II-6, 7)

A. Infection of kidney or bladder

    1. Symptoms

        a. Blood in urine - dark red or bright red

        b. Change in normal characteristics of urine - dark yellow, cloudy, or foul odor

        c. Client complains of burning upon urination.

        d. Client complains of pain (location depends on where infection is).

        e. Change in vital signs (Temperature, pulse, and respirations may be normal or increased.)

        f. Confusion

        g. Incontinent

h. Frequency

2. Health care assistant responsibilities

a. Report any of the above to the charge nurse.

b. Encourage adequate fluid intake, especially of water and fruit juices.

c. Encourage client to urinate at least every three to four hours while awake.

d. Assure proper hygiene of perineal area; daily washing and proper wiping from front to back.

B. Retention - inability to empty bladder caused by poor muscle tone of bladder, obstruction of urethra, or damage to certain areas of nervous system

1. Symptoms

a. Client complains of difficulty passing urine.

b. Client complains of feeling of fullness in the bladder.

c. Client urinates in very small amounts and frequently.

2. Health care assistant responsibilities

a. Report any of the above to the charge nurse.

b. Try triggering mechanisms to help client relax and allow the sphincter muscle to open and release urine.

(1) Sound of running water

(2) Pouring warm water over the perineal area

(3) Putting client's hand in warm water

c. Assist the charge nurse with catheterization procedure if indicated.

C. Incontinence - inability to stop or control the passage of urine.

D. Renal calculi

a. Description

1. Renal calculi are stones that develop in the urinary system. They can form in any area of the system: the kidneys, ureters, or bladder.

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        2. The size of stones varies from the size of sand to the size of a lemon or larger.

        3. Small stones are often passed in the urine. As stones become larger, they can block or obstruct the flow of urine.

        4. Clients who are on bed rest for a long period of time frequently form renal calculi.

    b. Symptoms

        1. Pus in the urine (pyuria)

        2. Blood in the urine (hematuria)

        3. Difficulty and pain when passing urine (dysuria)

    c. Straining urine - the health care assistant's responsibility

        1. Always wear gloves when handling urine.

        2. Strain all urine through gauze or a disposable strainer.

        3. Discard the urine and save the stones.

        4. Send stones for laboratory analysis according to facility procedure.

V. Factors That Can Lead to Incontinence (II-8)

    A. Confusion - unable to understand where or when he/she is urinating

    B. Poor fluid intake - concentrated urine is irritating and causes frequent dribbling

    C. Sphincter muscle weakness which causes bladder to release urine unexpectedly

    D. Damage to nerves in bladder which prevents stimulation of a full bladder from signaling the brain

    E. Damage to brain which prevents person from feeling urge to urinate

    F. Dribbling after catheter removal due to irritation and reduction in the size of the bladder

    G. Limited mobility, restraint use, and lack of assistance in getting to the bathroom

    H. Over-medication

    I. Elevated temperature

J. Bladder infection

K. Health care assistant responsibilities

1. Ensure adequate fluid intake.

2. Assist with bladder training program; may need to get client up during the night or take to the bathroom more frequently than normal (every one to two hours).

3. Give good skin care to prevent irritation, infection, or decubiti.

VI. Special Measures for Abnormal Urinary Function

A. Indwelling catheter - a sterile tube inserted through the urethra into the bladder to drain urine; held in place by a small inflated balloon (HO 1)

1. Must be ordered by physician and inserted only by a licensed nurse

2. Relief of a partial obstruction in the urethra causing urinary retention requires catheterization

3. Important points about catheters

a. The bladder is considered sterile; the catheter and drainage tube and bag are a sterile system--this system is not to be opened except when the catheter or bag must be changed. If the system is opened, germs may enter, which could lead to an infection.

(1) Drainage tubing/bags should not be allowed to touch the floor; always hook to bed frame or chair. **(II-9)**

(2) When the bag is emptied, put on gloves. The drainage tube should not be allowed to touch the rim of the urine container, the floor, or left out of its pouch while the urine is being emptied. Hands must be washed every time a catheter bag is emptied.

(3) Drainage bag should be changed p.r.n. as directed by the charge nurse. **(II-10)**

(4) Check drainage in the bag and tubing every two hours. NOTE: Immediately report lack of urine output.

(5) Drainage bag should be emptied when it starts getting full or at the end of a shift; record amount emptied.

b. The urine drains by the principle of gravity.

(1) The catheter and tubing should always be free of bends or kinks.

(2) Tubing should always be coiled or looped instead of hanging loosely. Prevent tubing from hanging below the level of the drainage bag.

(3) The system should always be below the level of the bladder; if moved above, urine could flow back into the bladder.

c. The catheter tubing should never be pulled on.

(1) Taping it loosely to inner thigh or using a leg band helps prevent this.

(2) When transferring client from bed to chair, always move drainage bag over to chair before moving client. Do not step on tubing.

B. Texas/external catheter - may only be used for male clients; a condom-type device attached to the penis with a drainage bag (HO 1)

1. Health care assistant may apply or assist client--this is not a sterile system; use clean techniques.

2. Various types available, follow directions that come with external catheter for applying catheter.

3. Client will require daily peri care.

4. Frequently check area around catheter for proper circulation.

VII. Helping the Client Use the Urinal or Bedpan (HO 2)

A. Urinal

1. Always use a urinal cover.

2. Check the color and odor of urine before emptying the urinal.

3. Some men have difficulty urinating while lying down and should stand to use the urinal. If the client cannot stand, let him sit on the side of the bed. If he cannot place the urinal, wear gloves and place the penis in the urinal.

4. Never place urinal on the bedside stand. Plastic urinals have a hook type handle, which can be used to hang it from the bedside rail within the man's reach.

5. Always answer call bells immediately.

6. Put on gloves to empty a urinal.

7. Empty urinals immediately to prevent odors and the spread of microorganisms.

B. Bedpan - used for both urine and bowel elimination (II-11)

1. Always keep bedpans covered when carrying them.

2. You can warm a bedpan by running warm water over it. (II-12)

3. Putting powder on a bedpan will prevent it from sticking to the client's skin.

4. Keep bedpan clean.

5. Never put bedpans on the floor because there are germs on the floor. Always return bedpans to the bedside stand.

6. Never put the bedpan on the overbed table or bedside stand. Put it on the bed.

7. Always pull curtains or close the door to provide privacy for the client.

8. Using the bedpan is easier with head of bed elevated.

9. Fracture bedpan - has a thin rim and is about 1/2 inch deep. The smaller end is placed under the buttocks Fracture bedpans are used for persons in traction or for those who have a cast. (II-13)

10. Always measure urine output accurately in a graduate measuring container if client is on I & O.

VIII. Assisting Client to the Bathroom (II-14)

A. If client has been in bed for an extended time and exhibits signs of dizziness, stay with him/her to assist in case of weakness or fainting.

B. Always be sure that the bathroom door remains unlocked.

C. Check that the floor is clean and dry to prevent client from falling.

D. Keep signal cord handy for client in case of emergency.

E. Observe characteristics of stool/urine before toilet is flushed.

F. Assist/remind client to wash hands.

G. Assist client back to bed if necessary.

H. Make client comfortable and place signal cord within reach.

I. Record observations.

J. Report anything unusual to charge nurse.

K. Always assist client to bathroom as soon as the request is made.

IX. Demonstrate Procedures for Giving Peri Care with Catheter, Changing a Drainage Bag, and Assisting with Urinals. **(II-15 - 17)**

X. Summary and Conclusion

A. Terms and definitions

B. Factors which maintain urine elimination

C. Normal urine characteristics

D. Conditions that may cause abnormal urine elimination

E. Factors that can lead to incontinence

F. Special measures for abnormal urinary function

G. Helping the client use the urinal or bedpan

H. Assisting client to bathroom.

I. Review procedures for giving peri care with catheter, changing a drainage bag, and assisting with urinals.

It is our goal to properly maintain the basic body function for each of our clients. Incontinence should not be assumed when one talks about the elderly. Many of our clients just need guidance and support in regaining control of this function. Keep in mind the importance of your observation skills. It may be up to your four senses to detect a problem. The next lesson is urine specimen collection.

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

STEPS OF PROCEDURE FOR GIVING PERI CARE WITH CATHETER:

1. Wash your hands. Put on gloves.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Client should be in supine position with legs apart; place bed protector under buttocks.
7. Cover client with bath blanket, then remove top sheet.
8. Check catheter and drainage bag for leaks, kinks, level of bag, character of urine, and that it is securely attached to bed frame.
9. Expose the perineal area.
    a. Separate the labia of the female client and gently wash around the opening of the urethra with soap and warm water.
    b. Gently pull back the foreskin of the male client and gently wash around the opening of the urethra with soap and warm water.
10. Wash the catheter tubing from the opening of the urethra outward four inches or farther if needed. Do not pull on the catheter.
11. Using a fresh washcloth, continue washing and rinsing the peri area. Dry the perineal area. (Follow procedure in Lesson Plan 25, Perineal Care.)
12. Remove bed protector and bath blanket. Place soiled linens in appropriate container.
13. Remove and clean equipment.
14. Remove gloves and dispose in appropriate container. Wash hands.
15. Store equipment.

16. Make the client comfortable; place call signal within reach.

17. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR CHANGING THE DRAINAGE BAG:

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

6. If applying a reusable leg bag, swab the end to be connected with alcohol and place on sterile gauze in alcohol packet. Do not allow it to touch anything else.

7. Crimp with your fingers or clamp the catheter tubing so urine does not flow.

8. Disconnect catheter tubing from drainage bag. Apply cap over end of tubing if reusing that drainage bag.

9. Connect leg bag to the catheter.

10. Unclamp catheter. Check to see that urine is flowing (may take a few minutes).

11. If placing a leg bag or applying new tape, allow enough slack so there is no pull on the catheter.

12. If drainage bag is to be reapplied later, remove the cap, swab the end with alcohol, and replace cap.

13. Remove and clean equipment.

14. Remove gloves and dispose in appropriate container. Wash hands.

15. Store equipment.

16. Make the client comfortable; place call signal within reach.

17. Record observations and report anything unusual to the charge nurse.

STEPS OF PROCEDURE FOR ASSISTING CLIENT IN USING URINAL:

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Turn back top bedding, except for top sheet. Expose the peri area.
7. Place the client's penis in the urinal and lay the urinal between his legs.
8. Make sure urinal is placed at an angle to keep urine from spilling out. Flat edge should be lying on bed.
9. Remove gloves and dispose in appropriate container.
10. Wash your hands.
11. Place signal cord within reach and leave the room.
12. Return to room promptly when client signals.
13. Wash hands. Put on gloves.
14. Remove and cover urinal, and take it to the bathroom.
15. Measure urine if on I&O and empty into toilet.
16. Clean equipment.
17. Remove gloves and dispose in appropriate container. Wash hands.
18. Store equipment.
19. Give client a clean, wet washcloth to wash his hands. Make client comfortable and place signal cord within reach.
20. Record observations and report anything unusual to charge nurse.

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

INTERACTION ITEMS:

1. What are the definitions of the terms: bladder, catheter, incontinent, kidneys, sphincter muscle, ureters, urethra, and urinate?
2. What are two factors that aid in maintaining urine output?
3. If the fluid intake is between 2,000 to 3,000 cc per 24 hours, what do you expect the output to be in 24 hours?
4. What hours of the day should the clients be encouraged to consume most of their fluid intake?
5. What are the characteristics of normal urine?
6. What are three conditions that may cause abnormal urine elimination?
7. What are the symptoms of a bladder infection and retention of urine?
8. What factors may lead to urinary incontinence in the elderly client?
9. Where are drainage bags/tubing placed?
10. How often are urinary drainage bags changed?
11. What are some points you should remember when giving and removing a bedpan?
12. What can you do to warm a bedpan?
13. What type of bedpan would you give a client who is in traction?
14. What are the responsibilities of the health care assistant when assisting client to the bathroom?
15. What are some points to remember when caring for a client with a catheter?
16. What part of the body do you wash first when giving catheter care?
17. How do you wash the catheter when giving peri care with a catheter?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show audiovisual.

2. Show students internal and external catheters.

3. Review anatomy of urinary system.

4. Instructor demonstrates catheter care and application of new bag or leg bag.

5. Students practice catheter care and application of new bag or leg bag.

6. Instructor demonstrates how to place a bedpan for a client who can help and one who cannot.

7. Students practice giving a bedpan to one another, simulating a client who can help and one who cannot help.

8. Instructor demonstrates collecting a routine urine specimen.

9. Students practice collecting a routine specimen.

10. Have the students discuss how they would feel if they had the urge to urinate and had to wait 15 to 30 minutes for someone to assist them to the bathroom.

ANSWERS TO EVALUATION ITEMS:

1. e
2. g
3. b
4. h
5. d
6. a
7. c
8. f
9. b
10. d
11. a
12. b
13. c
14. b
15. d
16. b
17. b
18. d
19. c
20. c
21. c
22. c

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS:

Match the following terms in Column I to correct definitions in Column II by writing the letter in the blank.

	Column I		Column II
___ 1.	Catheter	a.	The small passage from the bladder to the outside
___ 2.	Bladder	b.	Filtering system of the body
___ 3.	Kidneys	c.	Circle of muscle fibers around the urethra
___ 4.	Void	d.	Tubes that carry urine from kidneys to bladder
___ 5.	Ureters	e.	Sterile tube inserted into bladder to drain urine
___ 6.	Urethra	f.	Inability to control passage of urine
___ 7.	Sphincter	g.	Muscular sac that stores the urine in the body
___ 8.	Incontinent	h.	To pass urine

9. As a health care assistant, you are aware that the body needs an adequate intake of fluids for proper functioning of the urinary system. An adequate intake of fluids for a 24 hour-period is which one of the following amounts? (Circle the letter of the best answer.)

   a. 4 to 5 quarts
   b. 2,000 to 3,000 cc
   c. One quart
   d. 500 to 1,000 cc

10. Clients should be encouraged to consume most of their fluid intake between the hours of: (Circle the letter of the best answer.)

   a. 12 pm and 12 am.
   b. 5 am and 5 pm.
   c. 12 am and 9 am.
   d. 7 am and 7 pm.

11. Which one of the following is a normal characteristic of urine? (Circle the letter of the best answer.)

    a. Usual amount voided in 24 hours is 1,000 to 1,500 cc.
    b. Urine has a fruity odor.
    c. Urine is dark brown in color.
    d. Urine contains sediments and mucus.

12. A condition that may cause abnormal urine elimination is: (Circle the letter of the best answer.)

    a. Arthritis.
    b. Kidney infection.
    c. Depression.
    d. Sinusitis.

13. What symptoms of a bladder or kidney infection should be reported immediately to the charge nurse? (Circle the letter of the best answer.)

    a. Straw-colored urine and voiding every three hours
    b. Clarity of the urine is clear and frequency of urination
    c. Complaint of burning sensation and frequency of urination
    d. Voiding odorless urine every three hours

14. What are symptoms of retention of urine? (Circle the letter of the best answer.)

    a. Inability to control the passage of urine
    b. Complaints of a feeling of a full bladder and difficulty passing urine
    c. Voiding in large amounts every three hours
    d. Blood in the urine and frequency of urination

15. Factors that may lead to urinary incontinence include: (Circle the letter of the best answer.)

    a. Retention of urine.
    b. Eating foods with a high water content.
    c. Too much activity and excitement.
    d. Poor fluid intake and over medication.

16. Which one of the following is a true statement concerning urinary catheters? (Circle the letter of the best answer.)

    a. The drainage bag and tubing should be coiled on the floor.
    b. Drainage bags are emptied when they start getting full or at the end of the shift.
    c. The drainage bag is emptied weekly and checked daily for drainage.
    d. It is okay for the drainage tube to touch the rim of the urine container since it is sterile.

17. The urinary catheter tubing should:

a. Be moved to the chair after transferring the client to the chair.
b. Never have kinks in it and the system is below the level of the bladder.
c. Hang below the level of the catheter bag and hang loosely.
d. Always have the tubing pulled tightly when returning client to bed.

18. If a client cannot use a regular bedpan because of a cast, pain, or traction, you would give him/her a: (Circle the letter of the best answer.)

a. Urinal.
b. Commode.
c. Basin.
d. Fracture pan.

19. When giving peri care to a client with a catheter, the health care assistant should: (Circle the letter of the best answer.)

a. Wash the catheter tubing from the opening of the urethra outward 1 inch.
b. Wash the catheter tubing from the opening of the urethra inward 3 inches and farther if needed.
c. Wash the catheter tubing from the opening of the urethra outward 4 inches and farther if needed.
d. Wash the catheter tubing from the opening of the urethra outward a maximum of 2 inches.

20. If a client is unable to place a urinal, you should: (Circle the letter of the best answer.)

a. Ask a male health care assistant to place the urinal.
b. Tell the client you don't know how to place a urinal and get help.
c. Put on gloves and place his penis in the urinal.
d. Have him stand and face the side of the bed and place the urinal on the bed.

21. Bedpans are used for: (Circle the letter of the best answer.)

a. Urine elimination only.
b. All clients in the facility.
c. Urine and bowel elimination.
d. Bowel elimination only.

22. When assisting a client to the bathroom, it is the health care assistant's responsibility to: (Circle the letter of the best answer.)

a. Instruct the client to lock the bathroom door.
b. Take the client to the bathroom as soon as you have time.
c. Place the signal light where the client can reach it.
d. Flush the toilet stool before the client stands up from it.

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV: THE URINARY SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:_______________

GIVE PERI CARE WITH CATHETER

EQUIPMENT:

1. Chase doll
2. Basin - 1/2 full of warm water
3. Washcloths (2)
4. Mild soap
5. Disposable or reusable bed protector
6. Towel
7. Bath blanket
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Client should be in supine position with legs apart; place bed protector under buttocks.		
7. Cover client with bath blanket, then remove top sheet.		
8. Check catheter and drainage bags for leaks, kinks, level of bag, character of urine, and that it is securely attached to bed frame.		
9. Expose the perineal area. a. Separate the labia of the female client and gently wash around the opening of the urethra with soap and warm water.		
b. Gently pull back the foreskin of the male client and gently wash around the opening of the urethra with soap and warm water.		
10. Wash the catheter from the opening of the urethra outward four inches or farther if needed. Do not pull on the catheter.		

11.	Using a fresh washcloth, continue washing and rinsing the peri area. Dry the perineal area. (Follow procedure in Lesson Plan 25, Perineal Care.)		
12.	Remove bed protector and bath blanket. Place soiled linens in appropriate container.		
13.	Remove and clean equipment.		
14.	Remove gloves and dispose in appropriate container. Wash hands.		
15.	Store equipment.		
16.	Make the client comfortable; place call signal within reach.		
17.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "GIVE PERI CARE WITH CATHETER" according to the steps outlined.

____ ________________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:______________

CHANGE DRAINAGE BAG

EQUIPMENT:

1. Chase doll
2. Basin - 1/2 full of warm water
3. Washcloths (2)
4. Mild soap
5. Disposable or reusable bed protector
6. Towel
7. Bath blanket
8. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. If applying a reusable leg bag, swab the end to be connected with alcohol and place on sterile gauze in alcohol packet. Do not allow it to touch anything else.		
7. Crimp with your fingers or clamp the catheter tubing so urine does not flow.		
8. Disconnect catheter tubing from drainage bag. Apply cap over end of tubing if reusing that drainage bag.		
9. Connect leg bag to the catheter.		
10. Unclamp catheter. Check to see that urine is flowing (may take a few minutes).		
11. If placing a leg bag or applying new tape, allow enough slack so there is no pull on the catheter.		
12. If drainage bag is to be reapplied later, remove the cap, swab the end with alcohol, and replace cap.		

13. Remove and clean equipment.		
14. Remove gloves and dispose in appropriate container. Wash hands.		
15. Store equipment.		
16. Make the client comfortable; place call signal within reach.		
17. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "CHANGE DRAINAGE BAG" according to the steps outlined.

____

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

____

Date

LESSON PLAN: 58

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS: NAME OF STUDENT:________________

ASSIST CLIENT IN USING URINAL

EQUIPMENT:

1. Urinal and cover
2. Gloves

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Turn back top bedding, except for top sheet. Expose the peri area.		
7. Place the client's penis in the urinal and lay the urinal between his legs.		
8. Make sure urinal is placed at an angle. Flat edge should be lying on bed.		
9. Remove gloves and dispose in appropriate container.		
10. Wash your hands.		
11. Place signal cord within reach and leave the room.		
12. Return to room promptly when client signals.		
13. Wash hands. Put on gloves.		
14. Remove and cover urinal and take to the bathroom.		
15. Measure urine if on I&O and empty into toilet.		
16. Clean equipment.		
17. Remove gloves and dispose in appropriate container. Wash hands.		

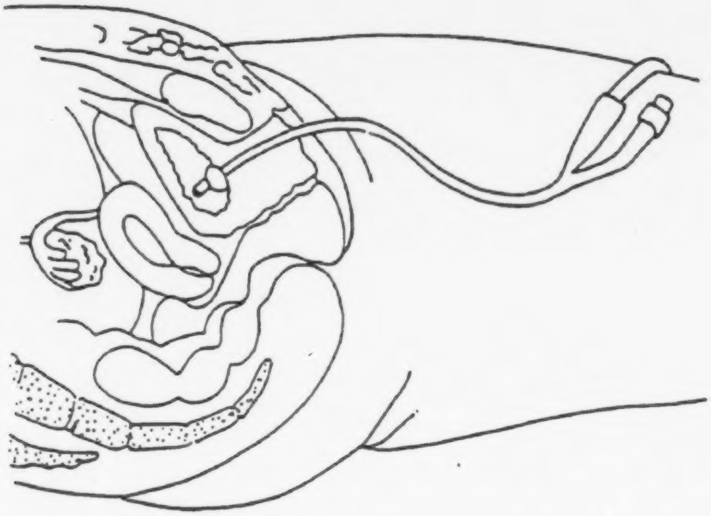
18.	Store equipment.		
19.	Give client a clean wet washcloth to wash his hands. Make client comfortable and place signal cord within reach.		
20.	Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "ASSIST CLIENT IN USING URINAL" according to the steps outlined.

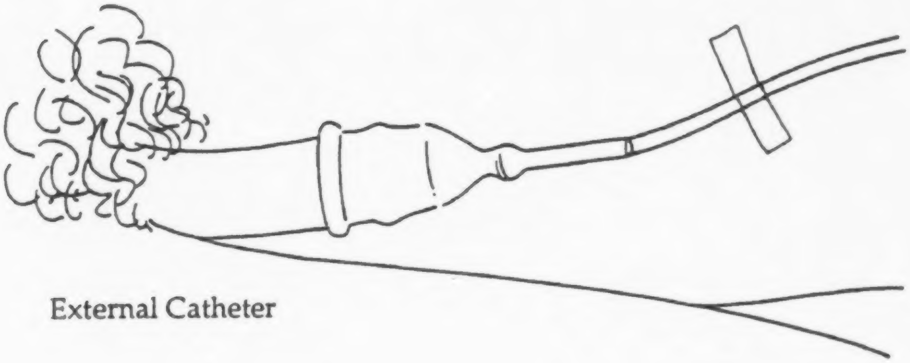
Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

CATHETERS

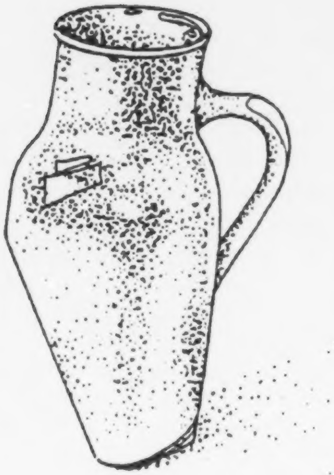


Indwelling Catheter

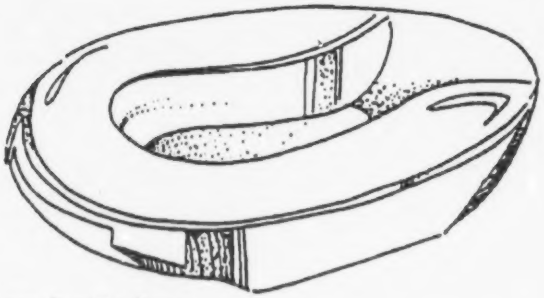


External Catheter

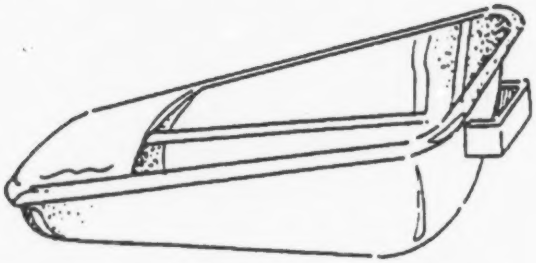
URINAL AND BEDPANS



Urinal



Regular Bedpan



Fracture Pan - Used for thin or disabled clients who do not have large stools

LESSON PLAN: 59

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV: THE URINARY SYSTEM

SCOPE OF UNIT:

The structure and function of the urinary system are examined. The medical terms and definitions pertaining to the urinary system are included. In addition, this unit covers all aspects of the elimination of urine; bladder and bowel retraining; giving and removing a urinal; collection of routine and clean-catch/midstream urine specimens; collection of a urine specimen from a catheter; changing a urine bag; and peri care for a client who has a catheter.

INFORMATION TOPIC: XIV-59 OR DEMONSTRATION:

BLADDER AND BOWEL RETRAINING
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Identify key concepts of a bladder retraining program.
3. Identify responsibilities of the health care assistant in a bladder retraining program.
4. Identify responsibilities of the health care assistant in a habit training program for clients with chronic bladder incontinence.
5. Identify responsibilities of the health care assistant in a bowel training program.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Sample Bladder Retraining Program

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 59 (Student Reference page 919) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 26.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 28.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 9, Section 5.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 10.

INTRODUCTION:

Bowel and bladder retraining is done in long-term care facilities or in home health care. Incontinence of urine and stool is the main reason for starting a client on a retraining program. It is a very embarrassing occurrence. You can imagine how you would feel if this happened to you. A consistent training program can help the client gain control of his/her bowel and/or bladder functions. This lesson will help you to understand which clients may be more successful with such a program, how we can retrain them to control their bladders and/or bowels again, and how to deal with chronic incontinence.

LESSON PLAN: 59

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

  A. Acute - rapid onset, short-term

  B. Chronic - drawn out, long-term

  C. Nocturia - to urinate during the night

II. Key Concepts of Bladder Retraining Program (HO 1) **(II-2)**

  A. For the client who has adequate mental and/or physical function to be retrained

    1. A client who has had a catheter inserted during an acute illness

    2. Recent urinary tract infection

    3. Stroke

  B. The client is given a measured amount of fluid regularly throughout the day and placed on a bedpan/bedside commode/or taken to the bathroom toilet to empty his/her bladder at specific times throughout the day and night.

  C. This program will help the client by strengthening the bladder and sphincter muscles and training the bladder control center in the brain to expect a regular pattern of urination.

  D. A retraining program ordered by the physician may be used for the client who still has a catheter. The catheter is clamped and opened for certain lengths of time. A schedule should be written by the charge nurse and followed by the nursing staff. The bladder retraining program will be continued after the catheter is removed until control of urinary function is regained.

III. Health Care Assistant Responsibilities **(II-3)**

  A. Providing adequate fluid intake is a must! It is needed to keep the urine diluted.

    1. A schedule of fluid intake should be set up by the charge nurse that the client and staff can follow.

2. You may need to remind the client to drink because the elderly have a decreased thirst sensation.

3. Keep an accurate I&O record.

4. Most fluids should be taken in between 7 a.m. and 7 p.m. to prevent nocturia.

B. A voiding schedule should be established and adhered to. **(II-4)**

   1. You must observe and record the client's usual pattern for a few days (48-72 hours) to determine a schedule; adequate fluid intake should be provided for during this time.

   2. If the client cannot stay dry for at least two hours, then he/she needs to be taken to the bathroom every two hours.

   3. If the client is dry for 3 to 4 hours, then taking him/her upon awakening in a.m., before and after meals, and at bedtime may be sufficient.

      a. If the client is independent and able to tell you, answer the calls promptly or offer your assistance at the usual times he/she voids.

      b. Measure and record urinary output.

      c. The client will need to be awakened during the night and assisted to the toilet if he/she usually voids during that time.

   4. Client can void easier in a upright position; standing for men and sitting for women.

   5. If the client is incontinent at times, keep him/her clean and dry; never scold the client if unsuccessful.

   6. Involve the client; explain the bladder control program to the client. If a client can accomplish this, it will help him/her to feel more confident, independent, and increase his/her self-esteem.

IV. Habit Training Program for Chronic Bladder Incontinence **(II-5)**

A. Clients who suffer from chronic bladder incontinence should be placed on a scheduled voiding or habit training program to keep him/her dry. (HO 1)

   1. Clients who have severe weakness of bladder and sphincter muscles

   2. Diseases/injuries causing brain damage of area that controls bladder function

   3. Enlarged prostate gland in males

B. Health care assistant responsibilities

1. Observe and record the client's usual times for voiding for a few days to determine his/her pattern.

2. Set up a toileting schedule from observations to check client for incontinence. Generally a toileting schedule is every two hours. If this does not work, try every 90 min. If this does not work, try every 60 min.

3. Encourage p.o. liquids and record intake.

4. Remove incontinent briefs/pads and give good peri care. Apply fresh incontinent pads or briefs (according to manufacturer's or facility's directions).

5. Observe the skin for any signs of breakdown--redness, irritation, sores, etc.

6. Treat the client with respect; be understanding.

V. Bowel Training Program

A. A program set up to assist the client to eliminate at his/her usual time of day and to prevent incontinence of stool

B. Health care assistant responsibilities (II-6)

1. Observe and record client's usual pattern of bowel movements; include time of day (a.m./p.m.) and how often, for a week.

2. Assist client to bathroom toilet/bedside commode/bedpan at time of day that he/she usually defecates. Provide as much privacy as possible, allow plenty of time for client to finish, and assure a sitting position as much as possible.

3. Encourage adequate fluid intake and proper diet.

4. Encourage regular exercises

5. Suppositories may be ordered by the physician as part of the training program to promote a regular elimination pattern.

   a. The CMT or charge nurse inserts the suppository.

   b. The CMT or charge nurse will tell you how many minutes to wait before assisting the client to use the bathroom or bedpan.

6. Note time of elimination and character of stool. Report any changes in schedule to the charge nurse.

7. Be patient and understanding. If the client can accomplish this, it will help him/her to feel more confident, independent, and will increase his/her self-esteem.

8. If a client is unsuccessful with the program, follow the health care assistant responsibilities for habit training program for chronic incontinence.

VI. Summary and Conclusion

A. Terms and definitions

B. Key concepts of bladder training program

C. Health care assistant's responsibilities

D. Habit training program for chronic bladder incontinence

E. Bowel training program

The retraining of the bladder and bowels can be accomplished. It requires your time and patience. It can be frustrating if the client is not making progress, but we must keep a positive attitude for the client's sake throughout the scheduled program. It also can be very satisfying and rewarding to know that you have helped someone feel good about himself/herself by gaining confidence and control in this area. The next lesson will be collecting urine specimens.

LESSON PLAN: 59

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV: THE URINARY SYSTEM

INTERACTION ITEMS:

1. What do acute, chronic, and nocturia mean?
2. What type of client could be successful with a bladder training program?
3. What is the health care assistant's responsibilities in a bladder retraining program?
4. What should you do if a client who is on a bladder retraining program is incontinent?
5. What kind of program can be set up for clients who are not successful with the bladder training?
6. What kind of observations do you need to make prior to setting up a bowel training program?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Assign students to care for clients on bowel and bladder training programs.

ANSWERS TO EVALUATION ITEMS:

1.	c
2.	a
3.	b
4.	c
5.	d
6.	c
7.	Habit
8.	b
9.	T
10.	F
11	F
12.	F
13.	F
14.	T
15.	F
16.	T
17.	T
18.	T
19.	T
20.	F
21.	T

LESSON PLAN: 59

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

		Column I		Column II
____	1.	Chronic	a.	Rapid onset; short term
____	2.	Acute	b.	To urinate during the night
____	3.	Nocturia	c.	Long-term; drawn out

4. Which one of the following types of clients would a bladder retraining program NOT be ordered for: (Circle the letter of the best answer.)

    a. A client who has a catheter.
    b. A client who has had a stroke.
    c. A client who is unconscious.
    d. A client who has had a recent urinary tract infection.

5. The health care assistant's responsibility to a client who is in a bladder training program is which of the following: (Circle the letter of the best answer.)

    a. Tell the client to drink a lot of water and that you will be back at the end of the shift to check the amount.
    b. Tell the client he/she should drink a glass of water every two hours between 7 PM and 7 AM.
    c. Since the charge nurse sets the schedule for fluid intake, it is his/her responsibility to offer the fluids - say nothing.
    d. Instruct the client and any visitors to keep tract of what the client drinks when you are not in the room and keep an accurate I & O.

6. You are assigned to give Opal White care. She has a voiding schedule established by the staff. You check her bed and find she has been incontinent. Which one of the following would be the correct action for you to take in this situation? (Circle the letter of the best answer.)

   a. Tell her she must call you when she has to void and change the sheets in silence.
   b. Remind her you have other clients to care for and it is time-consuming to change the bed.
   c. Tell her you realize accidents can happen, change the sheet, and tell her the two of you will continue to work together to establish her bladder training.
   d. Say nothing but by your actions let her know you are unhappy that she soiled the sheets.

7. A client who is not successful with the bladder training program should be placed on a ________________________ training program.

8. How long should you observe and record the client's usual pattern of bowel movements before setting up a bowel training program? (Circle the letter of the best answer.)

   a. One month
   b. One week
   c. Two weeks
   d. Three weeks

For each of the following, write "T" if the statement is true, or "F" if it is false.

___ 9. The bladder and sphincter muscles are strengthened and the client is on a bladder training program.

___ 10. A client with a catheter should not be started on a program until the catheter has been removed.

___ 11. Fluids should be restricted if the client is incontinent of urine.

___ 12. The health care assistant should wait until the client asks to go to the bathroom when he/she is on a bladder training program.

___ 13. The position of a client when trying to void is not important.

___ 14. The incontinent client must be kept clean and dry to prevent skin breakdown.

___ 15. The client should be left alone at night and not gotten up to go to the bathroom.

___ 16. Providing privacy and allowing plenty of time to defecate are important to the client.

___ 17. Exercise helps the client to control the bowel.

___ 18. Suppositories may be ordered by the physician to help with bowel training.

___ 19. Ambulatory clients should use the bathroom toilet when they are on a bowel training program.

___ 20. Clients who are incontinent should be scolded.

___ 21. Bowel and bladder training helps the client to become more independent.

SAMPLE BLADDER RETRAINING PROGRAM

Time	Client voided Y or N	Client had some leaking LA=large amt. SA=small amt.	Dry Y or N	Amount Voided (cc)	Intake of fluids (cc and type)
12-1 am					
1-2 am					
2-3 am					
3-4 am					
4-5 am					
5-6 am					
6-7 am					
7-8 am					
8-9 am					
9-10 am					
10-11 am					
11 am-12 pm					
12-1 pm					
1-2 pm					
2-3 pm					
3-4 pm					
4-5 pm					
5-6 pm					
6-7 pm					
7-8 pm					
8-9 pm					
9-10 pm					
10-11 pm					
11 pm-12 am					

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

SCOPE OF UNIT:

The structure and function of the urinary system are examined. The medical terms and definitions pertaining to the urinary system are included. In addition, this unit covers all aspects of the elimination of urine; bladder and bowel retraining; giving and removing a urinal; collection of routine and clean-catch/midstream urine specimens; collection of a urine specimen from a catheter; changing a urine bag; and peri care for a client who has a catheter.

INFORMATION TOPIC: XIV-60 AND DEMONSTRATION: XIV-60

URINE SPECIMEN COLLECTION

(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms in this lesson with their correct definitions.
2. Identify general rules of collecting a urine specimen.
3. Describe a routine, clean-catch, and 24-hour urine specimens.

Demonstration

4. Collect a routine urine specimen.
5. Collect a clean-catch/midstream urine specimen.
6. Collect a urine specimen from a closed urinary drainage system.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Bedpan/urinal
2. Specimen container
3. Specimen label
4. Lab requisition slip

5. Alcohol sponge (catheter specimen)

6. Syringe with attached needle (catheter specimen)

7. Sterile specimen container (midstream urine specimen)

8. Antiseptic solution

9. Cotton balls

10. Discard container

11. Soap and water

12. Washcloth

13. Towel

14. Disposable gloves

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 60 (Student Reference page 929) prior to class and be prepared to discuss the information and return the demonstrations on collecting urine specimens.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 26.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 28.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 9, Section 5.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 10.

INTRODUCTION:

The body eliminates wastes, such as urine, stool, and sputum, which can be useful in diagnosing and treating an illness. It is a responsibility of the health care assistant to obtain these specimens. He/she must be aware of the importance of accuracy when collecting a specimen. Make sure it is the right specimen from the right client at the right time using the right procedure. If you are not absolutely sure of the instructions, check with the charge nurse. A client can be harmed if you make a mistake.

The purpose of collecting urine specimens is for laboratory study and to assist the doctor in making a diagnosis or in evaluating the effectiveness of a treatment. Always make sure you have accurately filled out the requisition slip which will accompany the specimen to the laboratory.

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

OUTLINE:

I. Terms and Definitions (II-1)

- A. Asepsis - free of microorganisms
- B. Clean-catch - collection of urine specimen that is not contaminated by anything outside the client's body
- C. Midstream - collecting the urine specimen between the time the client begins to void and the time he/she stops
- D. Urine specimen - a sample of urine taken from the client for laboratory evaluation

II. General Rules

- A. Wash your hands before and after collecting the urine specimen. (II-2)
- B. Wear gloves; observe Body Substance Precautions.
- C. Always use a clean container and one the right size for the specimen.
- D. Fill out the laboratory requisition accurately with all of the information requested.
- E. Never touch the inside of the container or lid.
- F. Collect the specimen at the time specified.
- G. Instruct the client that there must not be any stool in the urine specimen.
- H. Instruct the client to not put toilet paper in the bedpan. The client should put toilet paper in the toilet stool.
- I. Immediately after collecting a urine specimen, take it to the laboratory or the area where it is to be stored.

III. Type of Urine Specimens (II-3)

- A. Routine urinalysis
  - 1. Done on all clients admitted to a hospital

2. Done in doctor's office for physical examines

3. Done before surgery

4. The client can usually collect this specimen by himself/herself and sometimes brings the specimen from home

B. Clean-catch/midstream

1. Before collecting the specimen, the perineal area is cleaned to reduce the number of microbes in the urethral area.

2. The client begins to void into the urinal/toilet.

3. Then the stream is stopped, and the specimen container is placed to collect the urine specimen.

4. If you have to assist the client, be sure to wear gloves.

C. 24-hour urine specimen

1. Urine is collected for 24 hours.

2. The urine is kept in a container in a pan of ice or in the refrigerator to prevent microorganisms from growing in it.

3. When the test is begun, the client voids and this first voiding is discarded.

4. All urine for the next 24 hours is collected.

D. Collecting a urine specimen from an infant

1. Collection bag is applied over the urethra.

IV. Demonstrate Procedures for Collecting a Routine Urine Specimen, Collecting a Clean-catch/Midstream Urine Specimen and Collecting a Urine Specimen from a Closed Drainage System.

V. Summary and Conclusion

A. Terms and definitions

B. General rules

C. Types of urine specimens

D. Review procedures for collecting routine urine specimen, collecting clean-catch/midstream urine specimen, and collecting specimen from closed drainage system

This lesson covered terms and definitions related to the collection of urine specimens, general rules for the health assistant to observe when collecting urine specimens, and the procedures for collecting urine specimens. The next unit is on the reproductive system.

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV: THE URINARY SYSTEM

STEPS OF PROCEDURE FOR COLLECTING A ROUTINE URINE SPECIMEN:

1. Wash your hands. Put on gloves.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Wash the client's perineal area if it is soiled, otherwise it is not necessary.
7. Offer a clean bedpan/urinal or assist to bedside commode/toilet fitted with speci-pan.
8. Ask client to void.

   NOTE: Instruct client not to put toilet paper or pass stool in receptacle used to collect urine.
9. Take covered bedpan/urinal to the client's bathroom or dirty utility room.
10. If client is on output, note amount of urine voided and record on I&O.
11. Carefully pour urine into specimen container, fill it 3/4 full, if possible.
12. Cover container tightly and securely. Apply identification and biohazard labels.
13. Pour leftover urine into toilet/hopper.
14. Remove and clean equipment.
15. Remove gloves and dispose in appropriate container. Wash hands.
16. Store equipment.
17. Make the client comfortable; place call signal within reach.
18. Inform charge nurse that specimen has been collected.
19. Record that specimen has been obtained.

STEPS OF PROCEDURE FOR COLLECTING CLEAN-CATCH/MIDSTREAM URINE SPECIMEN

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do and provide privacy.

5. Fill out label for laboratory.

6. Clean peri area with soap and water if soiled.

7. Apply antiseptic solution to cotton balls.

8. a. Female client

    1. Spread labia and expose urinary opening.

    2. Using cotton ball with antiseptic solution on it, wipe from front to back on one side; discard cotton ball.

    3. With a second cotton ball, wipe from front to back on other side; discard cotton ball.

    4. With a third cotton ball, wipe down the center; discard cotton ball.

   b. Male client

    1. Hold penis just down from the head of the penis; retract the foreskin, if uncircumcised.

    2. Cleanse the head of the penis and urinary opening with a cotton ball with antiseptic solution on it using a circular motion, three times.

    3. Use a cotton ball once and then discard.

9. Ask client to start to urinate into bedpan/urinal/toilet.

10. After flow has started, ask client to stop urinating.

11. Place specimen container under client and ask him/her to start urinating again into container.

    NOTE: Do not allow anything to touch the inside surfaces of the specimen container or lid. This would contaminate the specimen.

12. If client cannot stop urinating once he/she has started, move container into the stream of urine to collect the midstream specimen directly into container.

13. Remove container before the flow of urine stops.

14. Cover container tightly. Apply label.

15. Pour leftover urine into toilet/hopper.

16. Clean bedpan and store in proper place.

17. Remove gloves and wash your hands.

18. Have client wash hands.

19. Make the client comfortable; place call signal within reach.

20. Inform charge nurse that specimen has been collected; if it is not sent to lab immediately, store according to facility's policy.

21. Record that specimen has been obtained.

STEPS OF PROCEDURE FOR COLLECTING SPECIMEN FROM CLOSED URINARY DRAINAGE SYSTEM:

1. Wash your hands. Put on gloves.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do and provide privacy.

5. Fill out label for laboratory.

6. Close clamp on drainage tubing below the speci-port.

   NOTE: Never leave the bedside at this time without unclamping the tubing.

7. Cleanse the speci-port with the alcohol sponge.

8. Remove needle cover from syringe.

9. Insert needle into speci-port and pull gently back on the plunger to obtain required amount of urine.

10. Remove needle and syringe from speci-port. Cleanse the speci-port with a new alcohol sponge.

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11. Open clamp from drainage tubing. Check to see that urine is draining into drainage bag.

12. Place needle of syringe into specimen container and push plunger to expel urine into specimen container.

13. Cover container tightly. Apply label.

14. Take syringe, needle, and cover to proper container and dispose of them according to the facility's policy.

15. Pour leftover urine into toilet/hopper.

16. Clean bedpan and store in proper place.

17. Remove gloves and wash your hands.

18. Have client wash hands.

19. Make the client comfortable; place call signal within reach.

20. Inform charge nurse that specimen has been collected; if it is not sent to lab immediately, store according to facility's policy.

21. Record that specimen has been obtained.

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

INTERACTION ITEMS:

1. What are the definitions of asepsis, clean-catch, midstream, and urine specimens?
2. What are the general rules of collecting a urine specimen?
3. What is a routine urine specimen, clean-catch, and 24-hour urine specimen?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Demonstrate collection of urine specimen. (Coke or water may be used for the urine.)
3. Students collect urine specimens.

ANSWERS TO EVALUATION ITEMS:

1. b
2. c
3. d
4. a
5. b
6. b
7. c
8. a

LESSON PLAN: 60
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

Column I

___ 1. Urine specimen
___ 2. Clean-catch
___ 3. Asepsis
___ 4. Midstream

Column II

a. Collecting the urine specimen between the time the client begins to void and time they stop
b. A sample of urine taken from the client for laboratory evaluation
c. Collection of a urine specimen which is not contaminated by anything outside the client's body
d. Free of microorganisms

5. Which one of the following is a general rule of collecting urine specimens? (Circle the letter of the best answer.)

    a. It is not necessary to wear gloves.
    b. Never touch the inside of the container or lid.
    c. Instruct the client to put the toilet paper in the bedpan.
    d. It is okay to use urine from around stool for the specimen.

Match the type of urine specimen in Column I with the description in Column II.

Column I

___ 6. Routine urinalysis
___ 7. Clean-catch
___ 8. 24-hour urine specimen

Column II

a. Urine is collected for 24 hours
b. Done on all clients admitted to the hospital
c. Client begins to void, stops, container is placed, and then specimen is collected

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS: NAME OF STUDENT: ______________

COLLECT ROUTINE URINE SPECIMEN

EQUIPMENT:

1. Bedpan/urinal/speci-pan
2. Specimen container
3. Specimen label
4. Lab requisition slip
5. Soap and water
6. Washcloth
7. Towel
8. Gloves
9. Discard container

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do.		
5. Provide privacy.		
6. Wash the client's perineal area if it is soiled, otherwise it is not necessary.		
7. Offer a clean bedpan/urinal or assist to bedside commode or toilet fitted with speci-pan.		
8. Ask client to void. NOTE: Instruct client not to put toilet paper or pass stool in receptacle used to collect urine.		
9. Take covered bedpan/urinal to the client's bathroom or dirty utility room.		
10. If client is on output, note amount of urine voided and record on I&O.		
11. Carefully pour urine into specimen container, fill it 3/4 full, if possible.		

12. Cover container tightly and securely. Apply identification and biohazard labels.		
13. Pour leftover urine into toilet/hopper.		
14. Remove and clean equipment.		
15. Remove gloves and dispose in appropriate container. Wash hands.		
16. Store equipment.		
17. Make the client comfortable; place call signal within reach.		
18. Inform charge nurse that specimen has been collected.		
19. Record that specimen has been obtained.		

The student has satisfactorily completed the procedure "COLLECT ROUTINE URINE SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV: THE URINARY SYSTEM

EVALUATION ITEMS:

NAME OF STUDENT ____________

COLLECT CLEAN-CATCH/MIDSTREAM URINE SPECIMEN

Equipment

1. Bedpan/urinal
2. Sterile specimen container
3. Specimen container label
4. Lab requisition slip
5. Discard container
6. Soap and water
7. Washcloth
8. Towel
9. Gloves
10. Antiseptic solution
11. Cotton balls

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do and provide privacy.		
5. Fill out label for laboratory.		
6. Clean peri area with soap and water if soiled.		
7. Apply antiseptic solution to cotton balls.		
8. a. Female client		
1. Spread labia and expose urinary opening.		
2. Using a cotton ball with antiseptic solution on it, wipe from front to back on one side; discard cotton ball.		
3. Wipe from front to back on other side; discard cotton ball.		
4. Then wipe down the center and discard cotton ball.		
b. Male client		

1.	Hold penis just down from the head of the penis; retract the foreskin, if uncircumcised.		
2.	Cleanse the head of the penis and urinary opening with a cotton ball with antiseptic solution on it using a circular motion, three times.		
3.	Use a cotton ball once and then discard.		
9.	Ask client to start to urinate into bedpan/urinal/toilet.		
10.	After flow has started, ask client to stop urinating.		
11.	Place specimen container under client and ask him/her to start urinating again into container. NOTE: Do not allow anything to touch the inside surfaces of the specimen container or lid. This would contaminate the specimen.		
12.	If client cannot stop urinating once he/she has started, move container into the stream of urine to collect the midstream specimen directly into container.		
13.	Remove container before the flow of urine stops.		
14.	Cover container tightly. Apply label.		
15.	Pour leftover urine into toilet/hopper.		
16.	Clean bedpan and store in proper place.		
17.	Remove gloves and wash your hands.		
18.	Have client wash hands.		
19.	Make the client comfortable; place call signal within reach.		
20.	Inform charge nurse that specimen has been collected; if it is not sent to lab immediately, store according to facility's policy.		
21.	Record that specimen has been obtained.		

The student has satisfactorily completed the procedure "COLLECT CLEAN-CATCH/MIDSTREAM URINE SPECIMEN" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 60

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XIV : THE URINARY SYSTEM

EVALUATION ITEMS: NAME OF STUDENT ____________

COLLECT SPECIMEN FROM CLOSED URINARY DRAINAGE SYSTEM

Equipment

1. Syringe with attached needle
2. Sterile specimen container
3. Specimen container label
4. Lab requisition slip
5. Discard container
6. Soap and water
7. Washcloth
8. Towel
9. Gloves
10. Antiseptic solution
11. Alcohol sponge

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash your hands. Put on gloves.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what you are going to do and provide privacy.		
5. Fill out label for laboratory.		
6. Close clamp on drainage tubing below the speci-port. NOTE: Never leave the bedside at this time without unclamping the tubing.		
7. Cleanse the speci-port with the alcohol sponge.		
8. Remove needle cover from syringe.		
9. Insert needle into speci-port and pull gently back on the plunger to obtain required amount of urine.		
10. Remove needle and syringe from speci-port. Cleanse the speci-port with an alcohol sponge.		

11. Open clamp from drainage tubing. Check to see that urine is draining into drainage bag.		
12. Place needle of syringe into specimen container and push plunger to expel urine into specimen container.		
13. Cover container tightly. Apply label.		
14. Take syringe, needle and cover to proper container and dispose of them according to the facility's policy.		
15. Pour leftover urine into toilet/hopper.		
16. Clean bedpan and store in proper place.		
17. Remove gloves and wash your hands.		
18. Have client wash hands.		
19. Make the client comfortable; place call signal within reach.		

The student has satisfactorily completed the procedure "COLLECT SPECIMEN FROM CLOSED URINARY DRAINAGE SYSTEM" according to the steps outlined.

Instructor's/Approved Clinical Supervisor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 61

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XV : THE REPRODUCTIVE SYSTEM

SCOPE OF UNIT:

The structure and function of the reproductive system are examined. Medical terms and definitions pertaining to the reproductive system are included. The reproductive process and conditions and disorders of the reproductive system are included.

INFORMATION TOPIC: XV-61 OR DEMONSTRATION:

REPRODUCTIVE SYSTEM
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match the terms in this lesson with the correct definitions.
2. Label the organs of the male reproductive system on an anatomy diagram.
3. Describe the functions of the male reproductive organs.
4. Label the organs of the female reproductive system on an anatomy diagram.
5. Describe the functions of the female reproductive system.
6. Describe the menstrual cycle.
7. Define menopause.
8. Describe the process of fertilization.
9. Match the disorders and diseases of the reproductive system with the correct description.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Male Reproductive System
2. HO 2: Female Reproductive System
3. "Human Reproduction," film, Missouri Department of Health

4. State Fair Community College Media Center

   Slide/tape HO-80-580: The Testes and Production of Spermatozoa
   Slide/tape HO-80-582: External Male Genitalia
   Slide/tape HO-80-583: External Female Genitalia
   Slide/tape HO-80-584: The Vagina, Uterus, and Fallopian Tubes
   Slide/tape HO-80-586: The Menstrual Cycle

5. Projector

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 61 (Student Reference page 941) prior to class and be prepared to discuss the information presented.

REFERENCES:

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Fong, Elizabeth; Elvira B. Ferris; Esther G. Skelley. Body Structures and Functions, 7th ed. Albany, NY: Delmar Publishers, Inc., 1989.

Anthony, Catherine Parker; Gary A. Thibodeau. Structure and Function of the Body, 7th ed.

Mosby's Medical and Nursing Dictionary, 2nd ed. St. Louis, MO: The C. V. Mosby Company, 1986.

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 5th ed. Philadelphia, PA: W. B. Saunders Company, 1992.
St. Louis, MO: Time Mirror/Mosby College Publishing, 1984.

INTRODUCTION:

This system is unique. While all other systems are essential for the continuation of one's life, the reproductive system is essential for the continuation of the species. The primary function is to produce a like being.

LESSON PLAN: 61

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XV : THE REPRODUCTIVE SYSTEM

OUTLINE:

I. Terms and Definitions **(II-1)**

A. Coitus - sexual intercourse

B. Orgasm - the climax of coitus

C. Ejaculation - expulsion of semen from the penis

D. Prepuce - foreskin of male penis

E. Spermatozoon or sperm - male sex cell; spermatozoa is plural form of spermatozoon

F. Testosterone - male masculinizing hormone

G. Cryptorchidism - undescended testes

H. Vasectomy - surgical removal of a section of the vas deferens; each of the separate ends of the vas deferens are tied off

I. Ovum - female sex cell

J. Ectopic pregnancy - ovum slips into the abdominal cavity and becomes fertilized there

K. Menarche - beginning of menses

L. Ovulation - when a mature egg cell is released into the fallopian tube

M. Zygote - fertilized ovum

N. Amniotic sac - shock absorbing sac filled with fluid which surrounds the embryo

O. Placenta - fetal membrane that attaches the fetus to the uterus and exchanges nutrients between the mother and fetus

P. Embryo - the fetus the first three months after conception

Q. Fetus - from third month of intrauterine period until birth

R. Gynecologist - specialist in treating female disorders

S. Gynecology - the branch of medicine treating diseases of women

T. Hysterectomy - removal or excision of the uterus

U. Mastectomy - excision of the breast

V. Mastoplasty - plastic surgery on the breast

W. Metrorrhagia - uterine bleeding

X. Oophorectomy - excision or surgical removal of an ovary

Y. Oophoritis - inflammation of an ovary

Z. Salpingitis - inflammation of the uterine tube

AA. Salpingo-oophorectomy - excision of the ovary and the uterine tube

AB. Spermicide - an agent that is destructive to spermatozoa

II. Male Reproductive System (HO 1) (II-2)

A. External genitals

1. Scrotum

a. A skin-covered pouch suspended from the groin region

b. The inside of the scrotum is divided into two sacs by a septum.

c. Each sac contains the testis, epididymis, the lower part of the vas deferens, and the beginning of the spermatic cord.

d. The spermatic cords are cylindrical tubes that cover the vas deferens, blood vessels, nerves, and lymphatics as they pass from the scrotum into the abdominal cavity.

2. Penis

a. Penis is covered with skin.

b. The glans is located at the distal end where the skin is folded to form the foreskin.

c. It expels urine and is the male organ of intercourse (coitus).

B. Internal male structure

1. Testes - gonads of the male (II-3)

a. They produce sperm and secrete male sex hormone.

b. The testes are small oval-shaped glands about 1 1/2 inches long and 1 inch wide

c. Sperm cells develop in the walls of the seminiferous tubule.

d. Each testis forms millions of sperm every month after puberty.

e. Each testis secretes the male hormone testosterone.

f. The three functions of testosterone are:

   (1) Masculinize,

   (2) Promote and maintain the development of the male accessory organs, and

   (3) Stimulate protein anabolism, which is responsible for the muscular development and strength of the male.

g. Spermatozoa contain all of the characteristics that a baby inherits from the father.

2. Ducts

   a. Epididymis - collects sperm cells and stores them until maturity

   b. Vas deferens - passageway for sperm

   c. Ejaculatory duct - ejaculate sperm

   d. Urethra - passageway for urine and sperm

3. Accessory male glands

   a. Two seminal vesicles

      (1) They secrete the gelatinous fluid part of the semen.

      (2) Each ejaculation has about 1 teaspoon of semen (3 to 5 milliliters). Each milliliter contains about 60 million sperm.

   b. Prostate gland

      (1) Adds alkaline secretion to semen

      (2) Urethra runs through the center of the prostate gland.

   c. Cowper's glands (bulbourethral)

(1) Located on either side of the urethra just below the prostate gland.

(2) It adds an alkaline secretion to the semen - sperm can survive and remain fertile longer in an alkaline fluid.

III. Female Reproductive System (HO 2) **(II-4)**

A. External genitals - vulva

1. Mons pubis
2. Clitoris
3. Orifice of urethra
4. Labia minora (small lips)
5. Hymen
6. Duct of bartholin's gland
7. Vagina
8. Labia majora (large lips)

B. Ovaries - main sex gland of the female - release ova and produce hormones **(II-5)**

1. Ovaries are located in the pelvic cavity.
2. Ovarian ducts open into the abdominal cavity and not directly to the ovaries.
3. Ovarian follicles - several thousand microscopic sacs make up each ovary.
    a. Each ovarian follicle contains an immature ovum.
    b. A mature ovum in its sac is called a graafian follicle.
    c. Females usually produce one mature ovum per month.
4. Ovaries secrete the hormones estrogen and progesterone.
5. Ovaries contain two endocrine glands.
    a. Graafian follicles secrete estrogen.
    b. Corpus luteum secretes progesterone and some estrogen.

6. Function of estrogen
    a. Female characteristics
    b. Stimulates epithelial cells to reproduce themselves; especially in the lining of the uterus
7. Function of progesterone
    a. Stimulates secretion by epithelial cells
    b. Decreases contractions by uterine muscle during pregnancy

C. Ducts
1. Fallopian tubes - guide ovum to uterus
    a. Tubes are about 4 inches long.
    b. Outer edge curves over the top edge of the ovaries.
    c. They open into the abdominal cavity.
    d. Fimbriae (finger-like folds located over the ovaries) help propel the ova down the oviduct into the uterus.

D. Uterus - receives fertilized ovum and provides housing and nourishment for fetus
1. It is pear shaped and about the size of a pear.
2. It is hollow and has a thick wall.
3. The uterine cavity expands during pregnancy.
4. It has three parts:
    a. Fundus - bulging, upper part
    b. Body - middle part
    c. Cervix - lower, narrow portion that extends into the vagina
5. Layers of the uterine wall
    a. Serous - outer wall
    b. Myometrium - middle layer; it is thick, smooth, and muscular
    c. Endometrium - inner mucous layer

6. Function

   a. Menstruation

   b. Pregnancy

   c. Labor

E. Vagina - serves as female organ of intercourse and the birth canal

   1. Extends from the cervix to the vulva

   2. Functions

      a. Receives the sperm

      b. Stretches during childbirth to allow delivery of infant

F. Breasts - provide milk for newborn

   1. Each breast consists of many lobes arranged in a circular formation.

   2. Lobes are surrounded by tiny ducts.

   3. Areola is the dark area that surrounds the nipple. Ducts open into this area.

   4. Milk secretion is stimulated by prolactin from the anterior lobe of the pituitary gland.

IV. Menstrual Cycle - Usually a 28-day Cycle

   A. Starts at puberty - average age is 12 to 15 years but can start anywhere between age nine and eighteen years of age. **(II-6)**

   B. Controlled by hormones from the pituitary gland and ovaries.

   C. Stages

      1. Follicle - last for 10 days **(II-7)**

         a. Anterior lobe of pituitary gland secretes follicle-stimulating hormone.

         b. It is carried through the blood stream to the ovaries.

         c. When the follicle-stimulating hormone reaches the ovary, it causes one follicle to mature, grow in size, and an egg cell to grow in it.

         d. The follicle fills with estrogen.

        e. The estrogen causes the endometrium to become thicker and the uterus to be ready for implantation of an embryo.

    2. Ovulation

        a. The estrogen in the blood stream reaches a high level.

        b. The pituitary gland stops producing the follicle-stimulating secretion.

        c. The luteinizing hormone is secreted by the pituitary gland.

        d. At this time, the female has three hormones in the blood stream:

            (1) Estrogen,

            (2) Follicle-stimulating hormone, and

            (3) Luteinizing hormone,

        e. These three hormones stimulate the mature follicle to break about the 14th day and ovulation occurs. **(II-8)**

    3. Corpus luteum stage - lasts about 14 days

        a. Luteinizing hormone causes corpus luteum to form.

        b. Corpus luteum secretes progesterone.

        c. Progesterone causes the endometrium to thicken.

    4. Menstruation stage - last approximately 4 days

        a. Menstruation occurs about the 28th day.

        b. If the embryo is not implanted in the uterus, progesterone inhibits further luteinizing hormone secretion.

        c. The corpus luteum breaks down.

        d. The endometrium becomes thinner and breaks down.

        e. A small amount of blood from the ruptured capillaries, extra layers of the endometrium, and the unfertilized egg are discharged from the body as menstrual flow.

V. Menopause

    A. The menstrual cycle ceases. **(II-9)**

B. Menopause occurs gradually about 45 to 50 years of age but can occur as early as 35 years of age.

VI. Reproductive Process

A. Fertilization (II-10)

1. Fertilization occurs in the outer 1/3 of the oviduct.

2. The ovum (zygote) divides, and in approximately 3 days, a solid mass of cells forms. It is now a single cell individual.

3. The cell continues to divide as it travels to the uterus.

4. In 10 days, it is implanted in the uterus.

5. Next, the amniotic fluid and placenta develop.

6. The organ systems begin to grow.

7. The fifth week the heart is beating.

8. All organ systems are formed by the fourth month.

9. Length of pregnancy is 280 days.

B. Normal pregnancy

1. Signs and symptoms

2. Prenatal care

3. Preparation for parenthood

C. Phenomena of labor

1. Signs

2. Three stages

a. First stage of labor

b. Delivery of newborn

c. Expulsion of placenta

D. Postpartum period

VII. Disorders and Diseases of the Reproductive System (II-11)

A. Pruritus - itching of vulva and anus

B. Benign prostatic hypertrophy - non-malignant enlargement of the prostate gland

C. Prostatitis - inflammation of the prostate gland

D. Cancer of the prostate - malignant tumor

E. Dysmenorrhea - painful menstruation (cramps)

F. Amenorrhea - absence of menstruation

G. Menorrhagia - excessive bleeding during menstruation

H. Pelvic infection (PID) - infections of the pelvic cavity caused by gonorrhea, streptococcus, or staphylococcus

I. Breast tumors - may be malignant or benign

J. Vaginitis - inflammation of the vagina

K. Cystocele - the urinary bladder protrudes into the vagina

L. Fibroid tumors - benign tumors of the uterus

M. Hydrocele - accumulation of fluid in the scrotum

N. Varicocele - veins within the scrotum enlarge

O. STD - sexually transmitted diseases (examples follow)

    1. Gonorrhea - caused by the gonococcus bacteria; contagious

    2. Herpes simplex genitalis - viral infection; causes lesions on the male and female genitalis

    3. Syphilis - caused by the spirochete, Treponema pallidum; it can involve any organ or tissue of the body

P. Anorchism - congenital absence of testes

Q. Orchitis - inflammation of the testis

VIII. Summary and Conclusion

A. Terms and definitions

B. Male reproductive system

C. Female reproductive system

D. Menstrual cycle

E. Menopause

F. Reproductive process

G. Disorders and diseases of the reproductive system

This lesson has covered the terms and definitions related to the reproductive system. You have identified the male and female reproductive organs, their structure and function. We have briefly discussed the disorders and diseases of the reproductive system. The next unit will be understanding the elderly.

LESSON PLAN: 61

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XV : THE REPRODUCTIVE SYSTEM

INTERACTION ITEMS:

1. What are the definitions of terms found in this lesson?
2. Where on the diagram of the male reproductive organs are the vas deferens, seminal vesicle, prostate, testis, penis, and epididymis located?
3. What are the functions of the testes, ducts, seminal vesicles, prostate gland and Cowper's gland?
4. Where on the anatomy diagram are the female reproductive organs located?
5. What are the functions of the ovaries, fallopian tubes, uterus, vagina, and breasts?
6. What age does the menstrual cycle begin?
7. How long does the follicle stage of menstruation last?
8. What day of the menstrual cycle does ovulation occur?
9. What is menopause?
10. How does fertilization take place?
11. What is the correct description of diseases and disorders presented in this lesson?

CLASSROOM, LABORATORY, SHOP, OR OTHER ACTIVITIES:

1. Use anatomical model(s) and discuss the organs and their function.
2. View films.
3. Invite guest speaker from Missouri Department of Health to discuss breast self-exam.
4. Explain the menstrual cycle.

ANSWERS TO EVALUATION ITEMS:

1. c
2. g
3. a

4. f
5. b
6. d

7. a. Vas deferens
   b. Seminal vesicle
   c. Prostate
   d. Testis (gonad)
   e. Penis
   f. Epididymis

8. a

9. a. Fallopian tube
   b. Ovary
   c. Uterus
   d. Vagina

10. d
11. b
12. c
13. c
14. c
15. d
16. f
17. a
18. b

19. a. Ovum
    b. Embryo
    c. Fetus
    d. First stage of labor
    e. Delivery of newborn
    f. Expulsion of placenta
    g. Postpartum period

LESSON PLAN: 61

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XV : THE REPRODUCTIVE SYSTEM

EVALUATION ITEMS:

Match the terms in Column I with the correct definitions in Column II.

	Column I		Column II
___ 1.	Spermatozoa	a.	Beginning of menses
___ 2.	Ovum	b.	The fetus the first 3 months after conception
___ 3.	Menarche	c.	Male sex cell
___ 4.	Zygote	d.	From the third month of intrauterine period until birth
___ 5.	Embryo	e.	The climax of coitus
___ 6.	Fetus	f.	Fertilized ovum
		g.	Female sex cell

7. Label the organs of the male reproductive system.

   a.

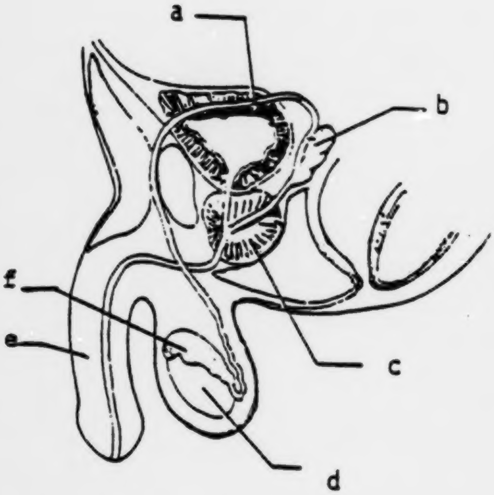
   b.

   c.

   d.

   e.

   f.



8. The functions of the testes are to: (Circle the letter of the best answer.)

   a. Produce sperm and secrete male sex hormone.
   b. Collect and store sperm cells until maturity.
   c. Secrete the gelatinous fluid part of semen.
   d. Add alkaline secretion to semen.

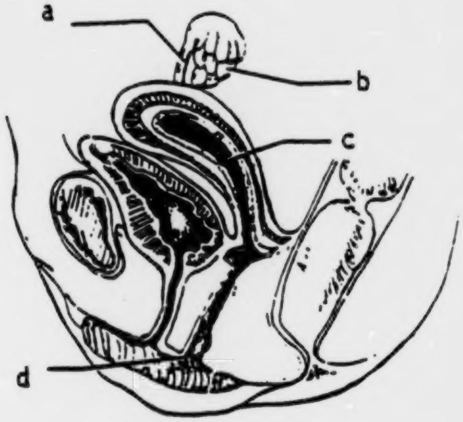
9. Label organs of the female reproductive system.

a.

b.

c.

d.



10. The function of the uterus is to: (Circle the letter of the best answer.)

    a. Release the female sex cell and produce hormones.
    b. Guide the ovum.
    c. Serve as female organ of intercourse and birth canal.
    d. Receive fertilized ovum and provide housing and nourishment for the fetus.

11. Which of the following statements are true concerning the menstrual cycle? (Circle the letter of the best answer.)

    a. The cycle is 30 days in length.
    b. Average age of onset is 12 to 15 years of age.
    c. The follicle stage last for 20 days.
    d. Ovulation occurs about the 5th.

12. Menopause is defined as: (Circle the letter of the best answer.)

    a. The time when old age begins.
    b. The beginning of the menstrual cycle.
    c. The time menstrual cycle ceases.
    d. A condition that occurs suddenly.

13. The heart of the embryo begins to beat at the: (Circle the letter of the best answer.)

    a. 1st week.
    b. 10th day.
    c. 5th week.
    d. 3rd month.

Match the disorder or disease of the reproductive system in Column I with the correct definition in Column II.

		Column I		Column II
___	14.	Orchitis	a.	Itching of vulva and anus
___	15.	Dysmenorrhea	b.	Excessive bleeding during menstruation
___	16.	Fibroid tumor	c.	Inflammation of the testis
___	17.	Pruritus	d.	Painful menstruation
___	18.	Menorrhagia	e.	Absence of menstruation
			f.	Benign tumors of the uterus

19. Place the items in the following list in the correct order of the growth and development process of normal pregnancy and childbirth.

Ovum
Expulsion of placenta
Embryo
First stage of labor
Fetus
Delivery of newborn
Postpartum period

a. ____________________

b. ____________________

c. ____________________

d. ____________________

e. ____________________

f. ____________________

g. ____________________

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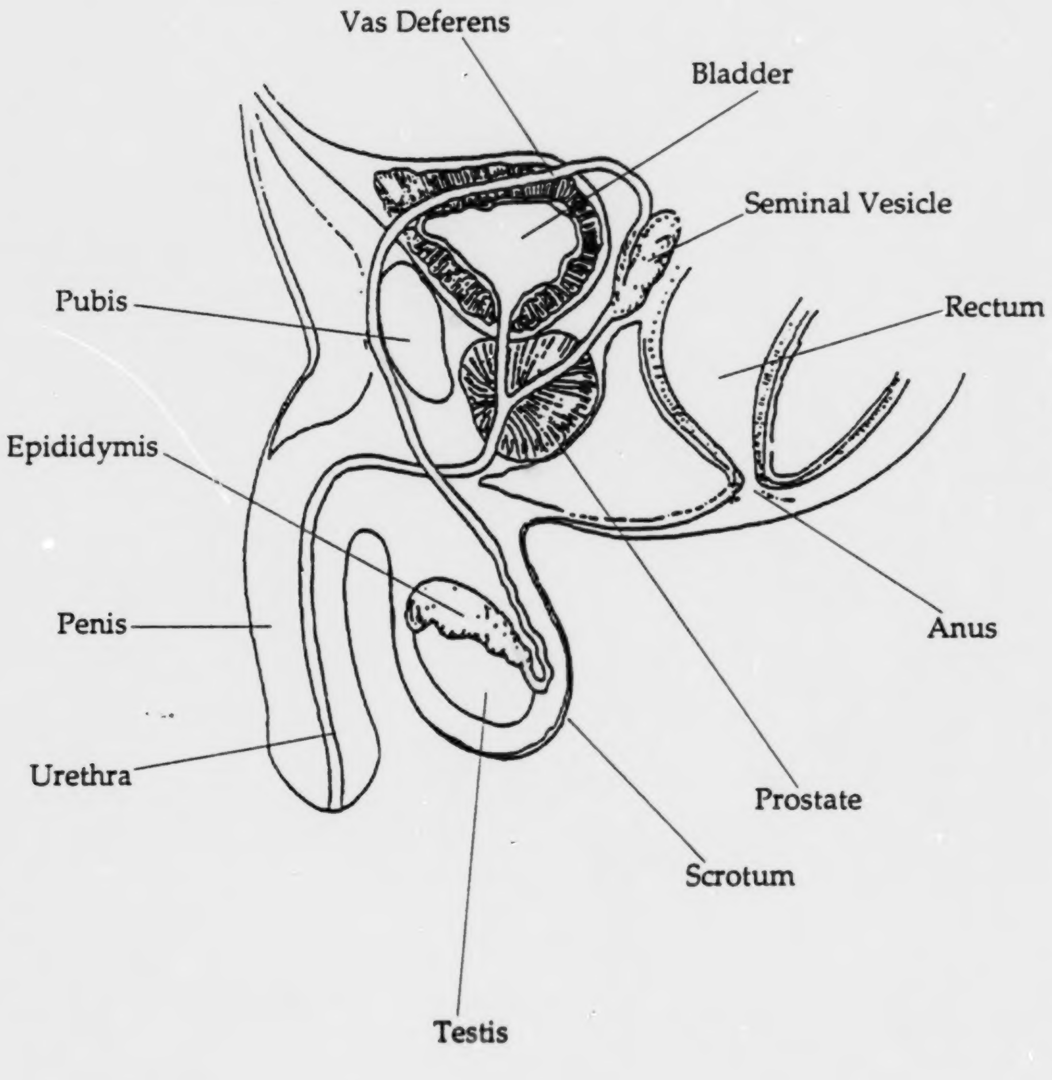
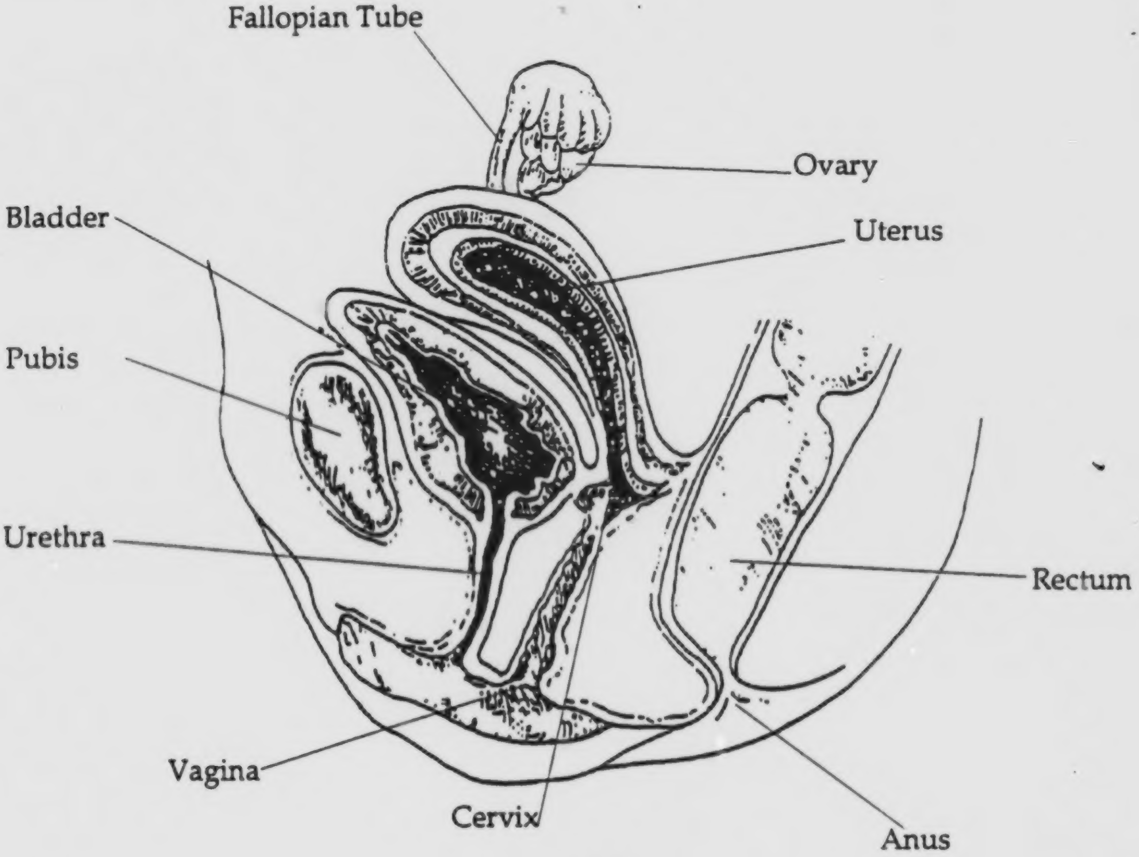
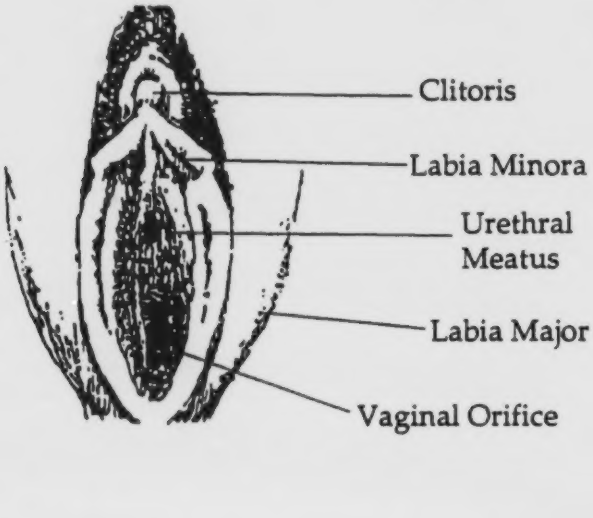
MALE REPRODUCTIVE SYSTEM


Vas Deferens
Bladder
Seminal Vesicle
Pubis
Rectum
Epididymis
Penis
Anus
Urethra
Prostate
Scrotum
Testis

FEMALE REPRODUCTIVE SYSTEM


Fallopian Tube
Ovary
Bladder
Uterus
Pubis
Urethra
Rectum
Vagina
Cervix
Anus


Clitoris
Labia Minora
Urethral Meatus
Labia Major
Vaginal Orifice

LESSON PLAN: 62

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

SCOPE OF UNIT:

This unit deals with the elderly individual. As a result of the aging process, significant changes occur in the human body. It is essential that the health care assistant be aware of the physical changes, mental changes, and social changes. We will discuss various health-related problems that you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: XVI-62 OR DEMONSTRATION:

THE AGING PROCESS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define atrophy and contracture.
2. Identify one physical sign of aging from each body system.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Life Stages
2. HO 2: The Aging Process: Nursing Care Points to Remember
3. HO 3: Age-Related Postural Changes
4. Perspectives on Aging, "Physical Changes and Their Implications" Program II, filmstrip, available from Concept Media
5. Audiovisuals available from the Missouri Vocational Resource Center
    a. The Confused Resident: Strategies for Quality Care, video #9, 25 min.
    b. Abnormal Signs and Symptoms, video #17, 10 min.
    c. Sharing the Burden (Alzheimer's), video #1, 1 hr. 45 min.
6. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Ready or Not, Here I Come, video (TF #78), 52 min.

   b. Caregiving with Grace, video (TF #74), 28 min.
   c. The Sixth Sense, video (TF #173), 27 min.
   d. Feeling Good with Arthritis, video (TF #154), 60 min.
   e. A Picture of Health, video (TF #1), 35 min.
   f. Common Physical Disorders of Elderly, 3 videos (TF #7), 5 hr. total
   g. Everybody's Doing It - 1988 Governor's Conference, video (TF #111), 45 min.
   h. Mirror, Mirror on the Wall, 16mm film (TF #26), 24 min.
   i. Physical Changes and Their Implications, video or slides/cassette (TF #31 Program 2), 30 min.
   j. Successful Aging Series, 6 35mm films/cassettes (TF #40, 40A, 40B, 40C, 40D, 40E), 100 min. total
   k. Working with Aged, video (TF #45), 45 min.
   l. Whisper, the Waves, the Wind, video (TF #50), 28 min.

6. Projector

7. Television and VCR

8. Chalk and blackboard

9. Skeletorso

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 62 (Student Reference page 957) prior to class and be prepared to discuss information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed., Baltimore, MD: Health Professional Press, 1991. Chapters 5-15.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 4.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 2.

Hegner, Barbara; Esther Caldwell. Nursing Assistant, A Nursing Process Approach, 6th ed. Albany, NY: Delmar Publishing, 1992, Unit 8.

INTRODUCTION:

Each day we grow older. There are many theories as to why the aging process occurs, but they are only theories. Maybe if we knew the reason for the aging process, some of the physical signs could be slowed down. The health care assistant needs to be aware of what changes take place as the body ages. Some of these changes are obvious. Some occur inside the body and are not visible, yet can influence the way care for the elderly client is given.

LESSON PLAN: 62

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

OUTLINE:

I. Terms and Definitions (II-1)

   A. Atrophy - decrease in size; waste away

   B. Contracture - when muscle tissue becomes shortened because of spasm or paralysis, either permanently or temporarily

II. Musculoskeletal System (HOs 1, 2, & 3)

   A. Muscular weakness - muscles gradually wear out; may atrophy due to disuse from inactivity--leads to contractures (II-2)

   B. Bones become lighter and more brittle

   C. Stiffening of joints

   D. Slumped posture due to deterioration of spine

III. Nervous System

   A. Normal aging causes some shrinkage of the brain, but:

      1. Only mild forgetfulness, no gross confusion

      2. Only mild slowing of movement, no major loss of balance

      3. Only mild impairment of sight and hearing

      4. Only mild changes in urinary function

   B. Major difficulty in any of the above functions is the result of disease, not normal aging

IV. Sensory System

   A. Decline in smell and taste

   B. Difficulty in distinguishing colors, increased light requirements

   C. Eyes adjust more slowly to light changes

- D. Dryness of eye (decrease in tears)
- E. Peripheral vision narrowed
- F. Progressive hearing loss of high pitched sounds
- G. Decreased perception of pain, heat, and cold by touch
- H. Decreased finger dexterity
- I. Reaction time is longer

V. Cardiovascular System

- A. Arteriosclerosis - blood vessels, especially arteries, harden and thicken, lose elasticity
- B. Atherosclerosis - fat deposits inside arteries making them narrower
- C. Heart wears out, decrease in amount of blood pumped, heart is not as effective a pump as once was
- D. Orthostatic hypotension - inability of cardiovascular system to adjust quickly enough to position changes; may cause dizziness and lead to fainting

VI. Respiratory System

- A. Lungs do not expand and contract as well, therefore, must breathe harder and longer
- B. Shallow breathing due to chest muscle weakness
- C. Cough not as effective due to muscle weakness

VII. Digestive System

- A. Loss of teeth, which results in less food consumption; diet consistency may need to be changed
- B. Do not need as many calories, but need same nutrition
- C. Movement of food slows in intestine due to poor muscle tone; prone to constipation
- D. Prone to gas due to decreased mobility of peristalsis

VIII. Urinary System

- A. Bladder opening weakens, resulting in incontinence and dribbling.

B. Decrease in bladder muscle tone may also result in urinary retention and infections.

IX. Reproductive System

A. Male - enlargement of prostate gland; decreased sperm production

B. Female - menstruation ceases; dryness of vagina

C. Most people continue to need a means of sexual expression either by association with another person or by self-stimulation

X. Endocrine System

A. Less hormone production

B. Muscle weakness

XI. Skin System - Integumentary

A. Brittle nails

B. Loss of subcutaneous fat causes chilling

C. Wrinkles due to loss of elasticity

D. Hair grays due to loss of pigmentation

E. Bruising - fragile blood vessels

F. Skin thins, dries, and loses elasticity due to decrease in oils and water

G. Discoloration - spotting

XII. Lymphatic System

A. Less resistance to disease and infection

B. Wound healing takes longer

XIII. Summary and Conclusion

A. Terms and definitions

B. Musculoskeletal system

C. Nervous system

D. Sensory system

E. Cardiovascular system

F. Respiratory system

G. Digestive system

H. Urinary system

I. Reproductive system

J. Endocrine system

K. Skin system

L. Lymphatic system

The next lesson is on emotional needs.

LESSON PLAN: 62

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI: UNDERSTANDING THE ELDERLY

INTERACTION ITEMS:

1. What are the definitions of terms presented in this lesson?
2. How many physical signs of aging from each body system can you name?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have the class discuss the aging process of each body system.
2. Show audiovisuals.

ANSWERS TO EVALUATION ITEMS:

1. c
2. d
3. a
4. d
5. c

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LESSON PLAN: 62

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

EVALUATION ITEMS:

1. What does atrophy mean? (Circle the letter of the best answer.)

   a. A broken bone
   b. Waste material coughed up from the lungs
   c. Decrease in size; waste away
   d. When muscle tissue becomes shortened because of spasm or paralysis, either permanently or temporarily

2. What is one sign of aging in the musculoskeletal system? (Circle the letter of the best answer.)

   a. Decreased perception of pain, heat, and cold by touch
   b. Decrease in bladder muscle tone may result in urinary retention
   c. Mild impairment of sight and hearing
   d. Slumped posture due to deterioration of spine

3. What is one sign of aging in the endocrine system? (Circle the letter of the best answer.)

   a. Less hormone production
   b. Brittle nails
   c. Eyes adjust more slowly to light changes
   d. Mild changes in urinary function

4. Which of the following is not a sign of aging in the cardiovascular system? (Circle the letter of the best answer.)

   a. Arteries harden and thicken.
   b. Fat deposits inside arteries makes the arteries narrower.
   c. The system is unable to adjust quickly to position changes.
   d. Bladder opening weakens, resulting in incontinence and dribbling.

5. Which of the following is not a sign of aging in the integumentary system? (Circle the letter of the best answer.)

   a. Skin wrinkles due to loss of elasticity.
   b. Hair grays due to loss of pigmentation.
   d. There is less resistance to disease and infection.
   c. Skin thins, dries, and loses elasticity due to decrease in oils and water.

HO 1

LIFE STAGES

I. Aging - Aging begins at birth and progressively continues until death.

II. Age groups

  A. Neonatal - birth to 1 month

    1. Normal weight is 6-8 pounds. Weight will vary - some mothers have larger babies than others.

    2. Average length is 19-21 inches.

  B. Infant - 1 month to 2 years

    1. Baby teeth erupt - 3 months

    2. Turn over - 3 months

    3. Sit monetarily - 3 months

    4. Crawl - 9 months

    5. Stand with support - 9 months

    6. Take first step - 1 year

    7. Say some words "mama" - 9 months

  C. Toddler - 2 to 3 years

    1. A time to explore and investigate their environment

    2. Time to begin potty training

    3. First part of this period is known as the terrible two's. They do not play well with other children. Although they begin to understand right and wrong, they are difficult to discipline. This is the "no" and "mine" stage.

    4. By the end of the toddler stage, they have improved motor skills, can walk and run, and can put words together.

  D. Preschool - 3 to 5 years

    1. More cooperative and sociable

    2. Become less dependent on the mother and more attached to the father

    3. Ask lots of questions - "why"

4. Play with other children

5. Have an active imagination

6. Curious concerning their sex organs

E. School age 6 to 12 years

1. Motor skills are more developed - play ball, write, etc.

2. Like friends of the same sex

3. Like clubs

F. Preadolescent 12 to 14 years

1. Secondary sex characteristics appear - develop breasts, hair growth under arms and pubic area, and menstruation

2. Become aware of the opposite sex

3. Want peer approval because of insecurity

4. Have wide mood swings

G. Adolescence - (14 to 20 years)

1. Sexual maturity has developed.

2. Want to be independent but also want the security of being dependent

3. Can make decisions

4. Have a value system

H. Adult - 20 to 50 years

1. Marriage

2. Have children

3. Form friendships

4. Choose a career

5. Usually have good health

I. Middle age - 50 to 65 years

1. Continue to advance in career
2. Children leave home. (Known as the empty nest period.)
3. Begin to slow down - health may not be as good as during the adulthood years.
4. Have the responsibility of aging parents
5. Retirement usually occurs.

J. Late maturity - 65 to 75 years.

1. Signs of aging appear - cannot do as much as previously able to do, problems with eye sight and hearing may occur
2. Chronic conditions such as arthritis are common.
3. A period of loss, such as loss of mate, move from home of many years to a smaller place, or friends die
4. A time to look at their lives and accomplishments or lack of accomplishments

K. Old age - 75 years and over

1. Become more dependent on others
2. Failing health
3. Loneliness
4. Death

HO 2

THE AGING PROCESS: NURSING CARE POINTS TO REMEMBER

I. Musculoskeletal System

1. Observe for signs of injury or disorders such as bruises, redness, swelling, complaints of pain, etc.
2. Use good safety measures: uncluttered halls, doorways, etc. Clean up spills, avoid hazardous conditions.
3. Encourage use of safety devices: handrails, bed rails, call bells, walkers, etc.
4. Provide aids to improve circulation: footrests, comfortable chairs, good positioning and body alignment, change of position, supportive devices
5. Encourage use of well-fitting, supportive shoes.
6. Encourage self-help and exercise within limits of client's capabilities and physician's orders.
7. Use care in handling and assisting; avoid bumping, bruising, or other injuries.
8. Support joints in positioning.
9. Assist with regular ROM and other exercises as ordered.
10. Encourage good nutrition including foods high in protein and calcium. Also encourage good fluid intake.

II. Nervous System

1. Be aware of need for good communication system. Give clear, simple directions. Use aids to communicate, if necessary, such as pictures, word cards, gestures, etc.
2. Use reality orientation.
3. Encourage activity, especially small groups.
4. Assist with ROM and other exercises--cooperate with PT department.
5. Provide for rehabilitation measures per physician's orders.
6. Provide a safe, secure environment.
7. Offer empathy, reassurance and encouragement.
8. Praise even small successes.
9. Several short periods of activity instead of one long, overtiring period should be encouraged.

III. Cardiovascular System

1. Observe for signs and symptoms such as edema, shortness of breath, pulse irregularity, cyanosis.
2. See that client avoids use of garters, tight fitting clothing, and positions which restrict circulation.
3. Turn and reposition client frequently. Elevate his/her extremities for better circulation.
4. Provide good skin care. Avoid pressure areas when positioning client.
5. Prevent bumps and bruises.
6. See that client uses support hose, if indicated and ordered.
7. Prevent exposure of client to infection.
8. Discourage overeating. Have client avoid salty foods and snacks.
9. Encourage exercise, or give ROM exercises.

IV. Sensory System

1. Provide good light for client.
2. Short periods of "eye work" such as reading and handwork should be encouraged to avoid eye strain.
3. Keep client's glasses clean.
4. Provide uncluttered, safe environment.
5. Check client's ears for wax--keep them clean.
6. DO NOT use sharp objects such as hairpins, Q-tips, etc. to clean ears.
7. Report earwax or other observations to charge nurse.
8. Learn how to operate hearing aids and encourage the client to use one, if needed.
9. Keep the helpless client's nose clean; trim unsightly hairs carefully.
10. Provide easy-access container for disposing of soiled tissue.
11. Provide good oral hygiene for all clients, but especially for the helpless. Encourage fluids.
12. Use good feeding techniques and check temperature of food before feeding.

V. Respiratory System

1. Avoid exposing client to colds and other respiratory infections.
2. Use good hand washing procedure.
3. Observe for and report symptoms such as difficulty breathing, coughing, rattling lung sounds, etc.
4. Encourage deep breathing when possible. Position to aid breathing--reposition frequently.
5. Avoid overtiring, but encourage exercise.
6. Discourage smoking.
7. Encourage fluids and juices.
8. Avoid sudden temperature changes. Use sweaters, lap blankets, etc. during winter and when air conditioning is on.

VI. Digestive System

1. Promote good oral hygiene--observe oral cavity and gums, denture fit, etc.
2. Observe for symptoms and complaints such as nausea, pain, distention, "heartburn," loss of appetite, constipation, diarrhea, etc.
3. Use good dietary procedures--encourage a balanced diet and allow plenty of time for client to eat. Encourage self-feeding. Use assistive utensils if needed.
4. Offer and encourage adequate fluids.
5. Encourage good toilet habits. Toilet regularly. Give privacy, ensure safety.

VII. Urinary System

1. Provide for regular toileting--remind client or take him/her if necessary. Allow for privacy and ensure safety.
2. Provide incontinent care and peri care/catheter care.
3. Implement and support bladder training program.

4. Offer encouragement--avoid ridicule of incontinent client. Keep dry--change soiled clothing.
5. Note amount, color, odor, and anything unusual about urinary output.
6. Observe for complaints of pain, burning, frequency, etc.
7. Observe male client for inability to void, swelling, etc.
8. Ensure adequate fluid intake, especially water. Push fluids if indicated. Record accurate intake and output measurements when ordered.

VIII. Reproductive System

1. Observe for signs of disorders
   Female - genital swelling, redness, itching, infected glands, vaginal discharge, bleeding, and odors
   Male - urinary symptoms, especially inability to void, scrotal swelling
2. Check breasts for lumps during bath.
3. Keep genitalia clean, especially uncircumcised male foreskin.

IX. Endocrine System

1. Encourage good nutrition; balanced diet.
2. Work with the diabetic to understand importance of diet, treatment, and exercises.
3. Observe for injury, sores, etc. especially the diabetic.
4. Keep client clean, especially good foot care.
5. Toenail trimming of diabetic should be done only by charge nurse.

X. Integumentary (Skin) System

1. Maintain close observation of skin condition, pressure points, and signs of skin problems.
2. Provide good skin care, keep client dry and clean, use lotion, backrubs with special attention to bony prominences.
3. Avoid pressure areas - turn and position frequently, at least every two hours.
4. Use supportive devices: pillows, "egg carton" or air mattress, sheepskin, and heel/elbow pads.
5. Regular bathing with attention to skin folds, perineal area, scalp, and feet. Avoid extremes of water temperatures.
6. Avoid injuries, bumping, bruising, and skin tears.
7. Encourage good nutrition - adequate fluid intake.
8. Encourage exercise.
9. Avoid tight clothing such as garters and restraints.

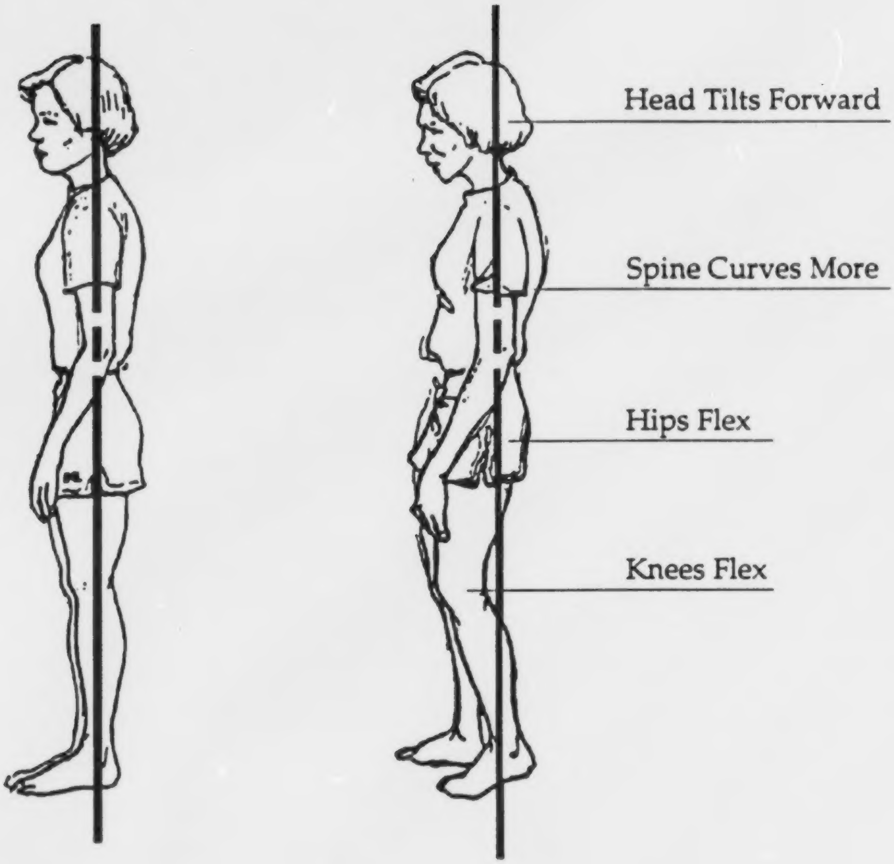
XI. Lymphatic System

1. Avoid injury to client and exposure to colds and other infections.
2. Note healing of sores and injuries.
3. Observe for glandular swelling, especially of neck, underarms, and groin
4. Report complaints of pain.

Developed by Ruth Shultz, RN. Used with permission.

HO 3

AGE-RELATED POSTURAL CHANGES


Head Tilts Forward
Spine Curves More
Hips Flex
Knees Flex

Some Reasons for Changes

1. Decline in muscle strength and flexibility
2. Thinning, brittle bones
3. Arthritis or other bone or joint diseases
4. Lack of physical activity

LESSON PLAN: 63

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI: UNDERSTANDING THE ELDERLY

SCOPE OF UNIT:

This unit deals with the elderly individual. As a result of the aging process, significant changes occur in the human body. It is essential that the health care assistant be aware of the physical changes, mental changes, and social changes. We will discuss various health-related problems that you will encounter daily.

INFORMATION TOPIC: XVI-63 OR DEMONSTRATION:

EMOTIONAL NEEDS
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify how the health care assistant can meet the client's basic physical needs.
2. Identify how the health care assistant can meet the client's safety and security needs.
3. Identify how the health care assistant can meet the client's need for love and belonging.
4. Identify how the health care assistant can meet the client's need for self-esteem.
5. Identify how the health care assistant can meet the client's need to reach full potential.
6. Identify major losses the client may have experienced.
7. Identify tasks the elderly must accomplish for successful aging.
8. List ways in which the client may cope if emotional needs are not met.
9. Identify various nursing approaches to satisfying the emotional needs of the client.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Client's Feelings
2. HO 2: Personal Needs

3. HO 3: Spiritual Care

4. Audiovisuals available from the Missouri Division of Aging Film Library

   a. Mildred: The First 90 Years, video (TF #183), 29 min.
   b. Depression in the Elderly - Diagnosis and Treatment, video (TF #10), 15 min.
   c. How to Create a Non-person, video (TF #4), 18 min.
   d. Coping with Difficult People, audiotape (TT #23), 1 tape

5. Television and VCR

6. Tape player

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 63 (Student Reference page 971) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapters 5 and 6.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Units 3 and 5.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 5.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 2.

INTRODUCTION:

Everyone has emotional needs. We must keep in mind that we are not just taking care of the physical needs of the client. Those needs sometimes seem more urgent, but that is not a reason to ignore the emotional needs which include psychological and social needs. A person goes through different stages of life learning to master new tasks so he/she can grow and develop. We will discuss what tasks are required of the elderly person and how he/she can be helped to cope in a positive manner with the aging process.

LESSON PLAN: 63

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

OUTLINE:

NOTE: The health care assistant helps clients meet their basic human needs. (HOs 1 & 2)

I. Basic Physical Needs **(II-1)**

   A. Food and fluids - providing adequate diet and fluids

   B. Clothing and shelter - helping to stay warm or cool

   C. Activity and rest - walk with client, ROM, assist to bed, comfortable position

   D. Elimination - able to urinate or defecate

   E. Sexual expression - ensure privacy rights

II. Safety and Security Needs **(II-2)**

   A. Health - good physical health; prevent illness

   B. Protection from injury - side rails, call light close

   C. Ability to help self - promote independence

   D. Own territory or space - allow privacy; client may personalize room with own furniture and personal belongings

III. Love and Belonging Needs **(II-3)**

   A. Sustaining relationships - encourage visits by friends; allow client to talk about the past

   B. Having someone who cares and to care for - this may be up to the health care assistant; listen to tales of the past, family, experiences; show interest in the client

   C. Meeting spiritual needs - assist to church services (HO 3)

IV. Self-esteem **(II-4)**

   A. Receiving respect and recognition (sense of identity) - call client by preferred name; respect privacy

B. Feeling important - praise client for accomplishments; acknowledge client at all times; respect privacy

V. Need to Reach Full Potential (II-5)

A. Satisfying use of time - encourage participation in activities

B. Having direction - allow him/her to talk about future, feelings about death

C. Venting feelings without shame - allow him/her to talk

D. Making decisions - allow client to make any choice possible, may be as simple as what he/she is going to wear today

VI. Losses Experienced by the Client (II-6)

A. Loss of health - physical and/or mental

1. Aging does not always mean illness.

2. The human body will eventually wear out.

3. Some behavior may be related to illness; example: client may be irritable and grouchy due to pain.

4. Sensory system gradually deteriorates, which may lead to confusion or withdrawal.

5. Loss of independence in care leads to poor self-image.

6. A change in appearance can cause client to have negative feelings about self.

B. Loss of spouse, family, friends, and pets

1. Creates a feeling of being all alone and that "no one cares," which can lead to depression

2. Client may not feel loved if no close family or friends are around to show it.

3. No one around for the client to love

4. No one to have intimate relationships with

5. Not able to feel as if needed by anyone

C. Loss of home and job

1. Less financial security without a job

2. Less feeling of being needed by society as a resourceful human

3. Miss the "home" environment

4. Loss of independence in maintaining a home and decision-making power

5. Loss of feeling important on the job or able to give to others

VII. Tasks the Elderly Must Accomplish for Successful Aging (According to Havighurst[1]) (II-7)

A. Learning to live with decreasing physical strength and health

B. Adjusting to retirement and reduced income

C. Adjusting to the death of a spouse

D. Establishing new relationships within own age group

E. Learning to be flexible in social roles

F. Arranging and carrying out satisfactory physical living arrangements

VIII. Coping Abilities of the Elderly (II-8)

A. If a loss in life or sudden illness comes rapidly, it may cause enough stress to make a person unable to cope with all that is happening.

B. Behaviors which may be related to upset emotional status:

1. Client becomes dependent. He/she does not want to take any responsibility for his/her life and has a poor self-image.

2. Client becomes overly-suspicious. He/she no longer trusts others and escapes from reality by blaming others for his/her troubles.

3. Client is jealous of time you spend with others, wants all of your attention.

4. Client becomes depressed due to loneliness, boredom, and losses he/she has experienced.

5. Client may be angry at prospect of becoming older and more dependent; may be due to all the losses he/she has suffered.

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[1] Fouts, Janet; Lynn Mullen. Nursing Assistant Training Manual. Beaverton, OR: Medi Form Printers and Publishers Inc., 1984, p. 13.

6. Client becomes withdrawn possibly due to being very lonely; may withdraw to a world of his/her own where he/she is not considered a "demented senior citizen."

7. Client may become confused/disoriented due to decreased efficiency of sensory system.

IX. Nursing Approaches (II-9)

A. Accept the client and his/her personality as is. Try to see the positive things about this person.

B. We may not approve of client's actions, but we let him/her know that we like client for himself/herself.

C. Make client as comfortable as possible--both physically and mentally.

D. The client must be treated in the same manner by all who work with him/her. One person should not grant special favors and another person forbid them. Utilization of care plans helps provide this consistency.

E. The client needs reassurance that he/she is still a functioning adult.

F. Client may need someone to talk to about his/her fears, worries, and anxieties. Be a good listener.

G. Respect client's dignity; never treat an adult as a child. Do not use such words as diapers, bibs, etc.

H. The client has a right to understand what is happening to him/her. Give thorough explanations before a procedure.

I. Never criticize or blame a client for not being able to perform certain tasks.

J. Be pleasant and friendly at all times. Leave your troubles at home so that you can smile often.

K. The client may be very sweet and agreeable to work with or he/she may be irritable, complain about anything and everything, use abusive language, or strike out at you. The client may take out his/her frustrations on the nearest person and it may be you. Accept the client quietly; allow him/her to "sound off".

L. Do not argue with a client.

M. The irritable client is often avoided and neglected by the health care assistant; if this is the case, he/she will only become more irritable.

N. It is easy to become emotionally involved with your clients. It is easy to love someone who is old and needs you! Meet their needs while you are with them. Do the best that you can as you care for them.

O. Due to loss of family or friends, the client may lack human contact and closeness. Don't forget to smile, squeeze a hand, and give a hug. They need our affection.

X. Summary and Conclusion

A. Basic physical needs

B. Safety and security needs

C. Love and belonging needs

D. Self-esteem

E. Self-realization

F. Losses experienced by the client

G. Tasks the elderly must accomplish for successful aging

H. Coping abilities of the elderly

I. Nursing approaches

Always keep in mind that the client is an adult with a lifetime of knowledge and experience; draw upon it--allow this adult to continue to thrive, make decisions, and participate in his/her own care. This will enhance self-esteem and feelings for independence. Be alert for clients whose behavior indicates their emotional needs are not being met. Try to help those individuals as best you can. You may refer to the social services designee for assistance in this area. The next lesson is on death and dying.

LESSON PLAN: 63

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

INTERACTION ITEMS:

1. What are five ways in which the health care assistant can meet the client's basic physical needs?

2. What are the four safety and security needs and how can they be met?

3. How can you as a health care assistant meet the client's need for love?

4. How can the health care assistant meet the client's need for self-esteem?

5. What are the four self-realization needs and how can they be met?

6. What are three major losses which the client may have experienced?

7. What are the five tasks which the elderly must accomplish for successful aging?

8. How will the client cope if emotional needs are not met?

9. How can you as a health care assistant approach the client to assist in satisfying his/her emotional needs?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide class into three groups. Assign one or two behaviors listed below. Have students role-play nursing approaches used in each situation.

   A. Dependent client

   B. Overly-suspicious client

   C. Jealous client

   D. Depressed client

   E. Angry/demanding client

   F. Withdrawn client

   G. Confused and disoriented client

2. Ask a client, your grandparents, parents or friends what it is like to grow old.

3. View audiovisuals.

ANSWERS TO EVALUATION ITEMS:

1. d
2. a
3. e
4. b
5. c
6. T
7. F
8. T
9. F
10. T
11. T
12. F
13. T
14. F
15. F

16. The student may list any three of the following:
    a. Dependent
    b. Overly-suspicious
    c. Jealous
    d. Depressed
    e. Angry
    f. Withdrawn
    g. Confused/disoriented

LESSON PLAN: 63

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

EVALUATION ITEMS:

Match the basic human need in Column I with the correct way the health care assistant can help meet that need in Column II by writing the letter in the blank.

Column I	Column II
___ 1. Self-esteem	a. Provide adequate diet and fluids
___ 2. Basic physical needs	b. Allow clients to make choices, encourage activities
___ 3. Love and belonging	c. Provide side rails, call light
___ 4. Self actualization	d. Call client by name, respect privacy
___ 5. Safety and security	e. Encourage family and friends to visit; show a caring attitude

For each of the following, write "T" if the statement is true or "F" if it is false.

___ 6. The elderly person needs to adjust to the physical changes of aging.

___ 7. The elderly person must not accept the death of a spouse.

___ 8. Loss of independence in care can lead to a poor self-image.

___ 9. Since the client is around so many people, he/she always feels he/she is needed and loved.

___ 10. The elderly client often feels his/her decision-making ability is lost.

___ 11. It is necessary to give thorough explanations before starting a procedure.

___ 12. If you do not approve of a client's behavior, let the client know that you do not like her or him and the behavior will improve.

___ 13. The client needs reassurance that he or she is still a functioning adult.

___ 14. It is appropriate to argue with a client if he/she is wrong.

___ 15. Avoid the irritable client so he or she will become less irritable.

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16. List three behaviors you may see if the client's needs are not being met.

a.

b.

c.

HO 1

CLIENT'S FEELINGS

Some clients, when they have need for complete care, no longer feel in control of themselves. As one such person tells the story of himself, "At times I felt as if I had lost my human qualities and did not belong to the species of human beings any longer. I felt like one of the sacks of produce I used to carry at one of my jobs. When I looked at my motionless hands, I saw a bunch of bananas. I had become a 'thing.'"

He goes on to say that as this thing he had become he was in constant need of attention and care from other human beings. "My most private and personal functions rested in the hands of others. I was a Martian dependent on Earthlings for my survival. I had no words that could adequately describe what I felt. I was exposed utterly and completely. I was vulnerable to everyone and everything. Nothing was private; there was only wordless shame for what I had become. These overwhelming feelings greatly sensitized me to those who cared for me. I looked over the faces of my health care assistants for their every mood and whim. Everything that affected them, affected me. If I was cared for willingly and without reluctance, I felt good and the world was sunny. If my care was given grudgingly or irritably in a callous way, powerful feelings of degradation swept over me."

"Some of the people I depended on made it clear that it was 'just a job' to them."

"Sometimes people would literally leave me in midair in the lift to go on a coffee break or leave me in some other awkward position and just say, 'It's my break time.' They would often do everything possible to avoid helping me. What they did was done in a perfunctory manner. They seemed reluctant or grudging as they did things. There was a guardedness about them, fearing that they would be asked to do more than they were willing or able to do."

"One of the worst times was at 'change of shift.' During that time there was absolutely no chance of getting anyone to help me, no matter how urgent the problem."

"We would wait expectantly to see who would ultimately be assigned to our ward."

"If it was 'Ivan the Terrible,' we knew we were in for trouble. If the doctors and nurses were the least bit surprised or irritated that Ivan had not done his job and ordered him to give this person a bedpan or that one a bath, he would be in an angry mood and then we were in for some rough handling."

"Others were nicknamed 'Leona the Late' because she was, and 'Ed the Reluctant,' so named because whatever request was made of him, he had to go someplace else first and usually would not return at all."

"To me, what they did or did not do was not 'just a job,' but a matter of survival of both my physical body and my sense of myself as a person. With callous helpers, I felt especially like an undeserving outsider--regarded at best with curiosity but usually with disinterest or disdain. Yet pity was no better. Feelings of humiliation would sweep over me at such times."

"Fortunately there was another sort of helper. Just thinking about them now I become warm and relaxed. These people helped willingly, with interest and compassion. They seemed to receive something valuable from the act of giving. My comfort was their goal. When one of them would appear on my unit, it was as though the room would suddenly light up. Fear and tension would recede."

"These willing health care assistants were among the most appealing people I have ever met. They seemed happy, generous, open, and compassionate. They were nurtured by their relationships with people who needed them. They usually had a remarkable sensitivity to the needs of people and often seeming to understand without words."

"With them I felt restored to the human community."

"They supported the best in me. Their generosity transformed both those they helped and themselves into richer, fuller human beings. The responsiveness of these compassionate helpers made me feel human again and brought forth the qualities in me that made it possible to be a support to others."

"Those who give grudgingly are the unlucky ones. Their guardedness divides them from other people so they get little back. They must feel like outsiders with most people."

"Getting enough air, being able to go to the bathroom when necessary, having enough food and rest are urgent needs, and I could do none of these elemental things for myself. When those needs were not met, I could not be compassionate to someone else. There is no opportunity for higher levels of human function when you are short of air and all that you can think about is getting the next breath. I am not good for anything else unless these needs are met."

"When I feel confident those around me would be willing to help if asked, I feel rather relaxed about it. I am willing to subordinate my needs to something which they need. I am willing to wait my turn because I know it will come, and while waiting, I am able and willing to reach out with some compassion for my care giver."

"In fact, most of the people who are the care givers are not different from those of us who receive the care giving."

"You get what you give. Goodwill begets goodwill."

"Disability has forced me to see how closely related I am to others. I am dependent on the supplies and moods of other people, of nature, of all things. Their fate becomes my fate. I must find ways of nurturing them, so they can nurture me."

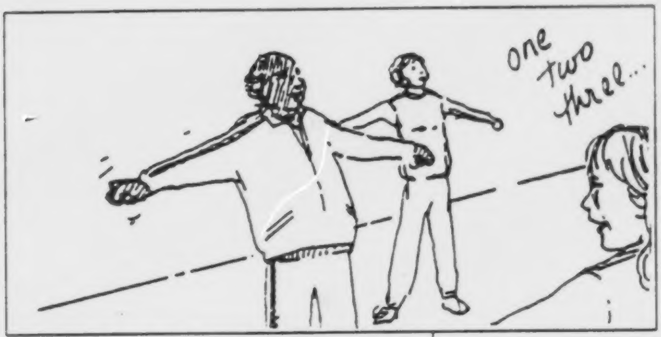
There are many instances where in long-term care the client cannot nurture support and care about the care giver, the health care assistant. Who then contributes to the nurturing and support of facility staff?

The best process is staff caring for staff. If there are particularly difficult clients to care for, discuss their needs and find new methods of giving care during a staff meeting. If you have a client dying or who has just died, have a staff meeting and discuss your concerns and feelings. Staff should support staff.

Credit: Deisser, Arnold. Flying Without Wings, Personal Reflections of Being Disabled, New York, NY: Doubleday Publisher, 1989.

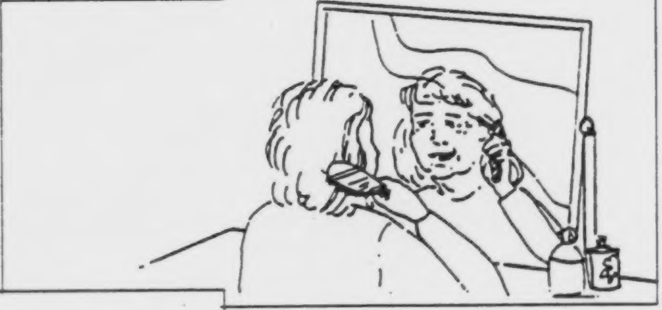
HO 2

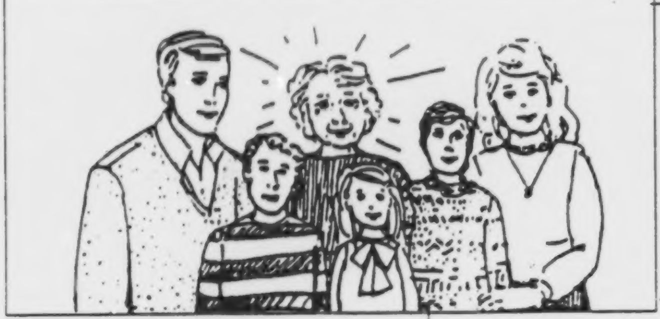
PERSONAL NEEDS



Need to Reach Full Potential

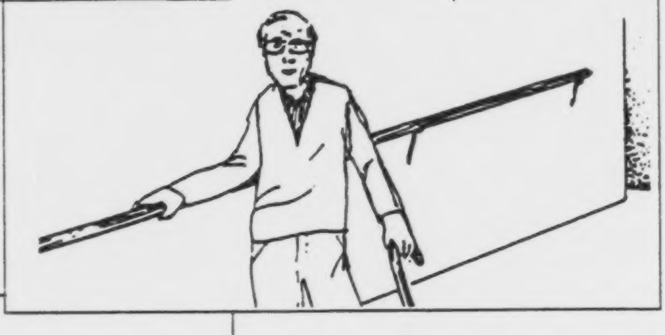
Need for Self-Esteem

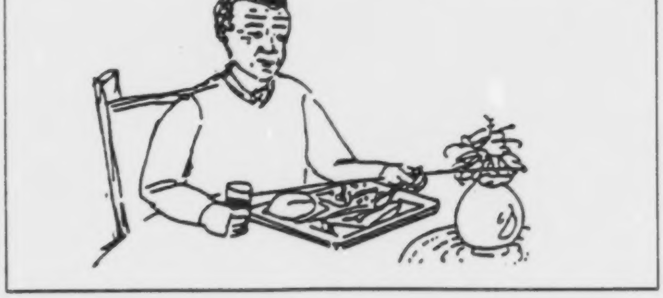




Need for Belonging and Love

Needs of Safety





Needs of the Physical Body

HO 3

SPIRITUAL CARE

Meeting the spiritual needs of clients in the health care facility is just as much a part of the client's life as is meeting the nutritional, hydration, sleep, safety, etc., needs of each client in the facility.

Spiritual care offers a sense of hope by helping clients find meaning and purpose in life for their physical, mental, and emotional problems. That hope may affect whether a client lives or gives up on life and dies.

Spiritual care is concerned with the total person. The interdependence of mind, body, and spirit is well known and medically acknowledged.

Our goal in giving spiritual care is to:

1. Give peace of mind to the client.
2. Build emotional stability which in turn will help heal the physical part of the body.

Staff can be a healing resource for the client. In order to enable the client to heal in these ways the health care assistant should:

1. Have a trusting relationship with the client (accept the client as he/she is).
2. Show dignity, respect, and value for the client as a person no matter what his/her physical or mental condition.

The need for spiritual care is important to all humans and especially so for many elderly. By giving the client hope, faith, and confidence, the health care assistant gives the client the ability to grow in the face of illness and despair. Even though the client may have no specific religious faith he/she can have a sense of spirituality. Spirituality means having a meaning for being.

The spiritual needs of the client may be met by doing some of the following:

1. Treating the client with respect.
2. Talking with and listening to the client.
3. Assisting a client to attend worship services.
4. Assisting in arranging for a memorial service for a client's friend in the facility who has died.
5. Assisting a client to attend a religious study group.
6. Being a supportive presence and showing empathy for the client.

As a member of the health care team, the health care assistant shares in helping the client reach the goals in the health care plan, utilizing the approaches outlined in the care plan. Meeting the spiritual needs of the client gives the client peace and hope.

LESSON PLAN: 64

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI: UNDERSTANDING THE ELDERLY

SCOPE OF UNIT:

This unit deals with the elderly individual. As a result of the aging process, significant changes occur in the human body. It is essential that the health care assistant be aware of the physical changes, mental changes, and social changes. We will discuss various health-related problems that you will encounter daily.

INFORMATION TOPIC: XVI-64 OR DEMONSTRATION:

DEALING WITH MENTAL CONFUSION
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms introduced in this lesson to correct definitions.
2. Name two methods of identifying confused clients.
3. List three causes of confusion.
4. Name two emotional or physical responses resulting from confusion.
5. List two behavioral responses resulting from confusion.
6. List two functional responses resulting from confusion.
7. Identify correct nursing approaches for the confused client.
8. Identify correct methods of dealing with problem behaviors resulting from confusion.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Understanding Mental Confusion
2. HO 2: Alzheimer's
3. The Confused Resident: Strategies for Quality Care, video #9, available from the Missouri Vocational Resource Center, 25 min.

4. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Designing the Physical Environment for Persons with Dementia, video (TF #184), 20 min.
    b. Do You Remember Love, video (TF #59), 2 hrs.
    c. Glenn's Perspective on Grace, video (TF #177), 22 min.
    d. Living with Grace, video (TF #21), 26 min.
    e. Perspectives on Grace: Nursing Care Implications, video (TF #115), 22 min.
    f. Someone I Once Knew, video (TF #37), 28 min.
    g. Stolen Memories (48 hours), video (TF #149), 60 min.
    h. Wesley Hall, video (TF #143), 28 min.
    i. Sherm, video (TF #148), 15 min.
    j. Before the Going Gets Rough (Part 1) & After the Going Gets Rough (Part II), video (TF #146)
    k. Compassion, I Suppose, video (TF #79), 30 min.

5. Projector

6. Television and VCR

7. The Older Voices Program, trainer's manual/resource guide (TR #001), available from the Missouri Division of Aging Film Library

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 64 (Student Reference page 983) prior to class and be prepared to discuss the information presented.

REFERENCES:

Nurse Assistant in a Long-Term Care Facility. University of Missouri-Columbia: Instructional Materials Laboratory, 1993.

Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapters 6 and 35.

Gentry, Linda. Confused Resident Care. University of Missouri-Columbia: Instructional Materials Laboratory, 1990.

Hegner, Barbara; Ester Caldwell. Geriatric: A Study of Maturity. 5th ed. Albany, NY: Delmar Publisher, 1991. Unit 28.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 11.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 11.

INTRODUCTION:

Confusion is when one's thoughts are mixed up. Some confusion lasts for a short time because the cause of that type of confusion can be treated. Other types of confusion are caused by factors that cannot be "cured" which include Alzheimer's Disease and stroke. In long-term care, clients' confusion will vary in cause and severity but, in general, they are confused in some way every day.

LESSON PLAN: 64

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

OUTLINE:

I. Terms and Definitions (II-1)

A. Acute - developing rapidly with pronounced symptoms and lasting a short time

B. Agnosia - loss of the ability to recognize familiar objects

C. Alzheimer's - a form of dementia that begins slowly, with an inability to name familiar objects

D. Aphasia - loss of the ability to use or understand language

E. Apraxia - loss of the ability to carry out planned movement at will

F. Catastrophic reaction - overreaction to circumstances

G. Chronic - continuing over a long period of time or recurring frequently; chronic conditions begin insidiously, and symptoms are not as noticeable as in acute conditions

H. Confused - state of being mixed up

I. Confusion - a mental state characterized by disorientation regarding time, place, or person

J. Dehydration - loss of body's normal water content, which can affect both physical and mental functions

K. Dementia - severe impairment of cognitive functions such as thinking, memory, and personality

L. Disorientation - the state of mental confusion or loss of bearings in relation to the sense of person, place, or time

M. Hallucination - sensory perceptions that seem real to the person experiencing them but are not perceived by others

N. Paranoia - suspiciousness inappropriate to reality - individual feels that everyone is picking on him/her or out to get him/her

O. Sundowning - phenomena when behavior problems become worse in evening

P. Wandering - aimless walking, which may result in a client becoming lost

II. Identification of Confused Clients (II-2)

A. Observation

B. Appropriate use of the reality orientation

III. Causes of Confusion (II-3)

A. Physical factors

1. Disease of the central nervous system (brain)

a. Senile dementia of the Alzheimer type

b. Stroke

c. Brain damage

2. Lack of oxygen to the brain

3. Fluid, electrolyte, and nutrition difficulties (dehydration)

4. Undetected infections (temperature elevation)

5. Elimination difficulties (constipation)

6. Effects of medication

B. Sensory/emotional factors

1. Lack of stimulation or over stimulation (sensory overload)

2. Misinterpretation of sensor input (either poor vision, hearing, or dementia--aphasia, agnosia)

3. Depression

4. Hallucinations, delusions

C. Environmental factors

1. New surroundings (adjustment)

2. Isolation (decreased contact with other than confused people)

3. Restraints

4. Misinterpretation of the environment

IV. Emotional or Physical Responses **(II-4)**

   A. Being suspicious

   B. Being rude, angry, insulting

   C. Being constantly restless or talkative

   D. Seeing things not there (hallucination)

   E. Hearing voices from past

   F. Reliving situations from past

   G. Not responding to anything

V. Behavioral Responses **(II-5)**

   A. Having difficulty remembering how to do simple tasks or not finishing things started

   B. Forgetting what day it is, what time of life, who you are

   C. Losing, hiding, or misplacing things and looking all over for them

   D. Wandering or getting lost

VI. Functional Responses **(II-6)**

   A. Unable to dress self

   B. Unable to feed self

   C. Unable to bathe, shower, or shave self

   D. Incontinent of bowel or bladder

VII. Nursing Approaches **(II-7)**

   A. Caregiving environment

      1. Treat client with dignity and respect.

      2. Know the client as an individual (his/her past, likes, and dislikes).

      3. Always introduce yourself, call the client by name, and explain what you are doing when you approach the client. Do this as many times as needed so they will remember who you are.

      4. Create a calm, orderly routine.

5. Familiarize clients to surroundings as often as necessary.

6. Provide mechanical aids as needed by client (hearing aids, glasses).

7. Provide sensory stimulation

    a. Conversation - encourage clients to talk about their families and past experiences

    b. Music

    c. Touch

    d. Group activity - have clients participate in a group activity each day; boredom can cause confusion

    e. Keep a calendar and clock in a visible place and refer to the time and date frequently.

B. Observe physical needs to maintain client's health.

1. Observe and report changes in thinking or memory.

2. Monitor nutritional and fluid intake.

3. Observe and report signs of infection besides an elevated temperature.

C. Use appropriate measures to maintain function.

1. Orient to appropriate holidays or activities related to the nursing home or client's life.

2. Conversation should include current interactions as well as those from past history.

3. Place familiar personal articles in room.

4. Encourage client's participation in activities outside his/her room.

5. Encourage visits, telephone calls, letters from family, friends, visitors, other clients.

6. Assist client to maintain appearance that he/she can be proud of.

7. Respond to feelings, display empathy, interest.

VIII. Problem Behaviors Resulting from Confusion **(II-8)**

A. Catastrophic reaction - overreaction, paranoia, sundowning, inappropriate sexual behavior, etc.

B. Suggestion for coping with these behaviors

1. Identify exactly the behavior to be examined or altered, separate from attitude.

2. Try to determine the cause of the behavior.

3. Plan and discuss ways to handle and react to the behavior with others involved in the client's care.

IX. Summary and Conclusion

A. Terms and definitions

B. Identification of confused clients

C. Causes of confusion

D. Emotional or physical responses

E. Behavioral responses

F. Functional responses

G. Nursing approaches

H. Problem behaviors resulting from confusion

A confused state of mind may be very frightening and upsetting to both the client and the caregiver. Sometimes caring for the confused person is difficult and frustrating because a "cure" is not always possible, and the confused person cannot or will not say "thank you" for your work. Although they are as vulnerable as children, the confused clients are not children and should not be treated that way. Your care can make the difference between good days and bad days. Your victories may come in small measure--shared awareness in the moment between you and a confused client--but recognize them as very important achievements and feel proud. The next lesson is on death and dying.

LESSON PLAN: 64
COURSE TITLE: HEALTH CARE ASSISTANT
UNIT XVI: UNDERSTANDING THE ELDERLY

INTERACTION ITEMS:

1. **What are the definitions of the terms in the lesson?**
2. **What are two methods of identifying confused clients?**
3. **What may cause a client to become confused?**
4. **What are the emotional or physical responses that may result from confusion?**
5. **What are four behavioral responses that may result from confusion?**
6. **What are four functional responses that may result from confusion?**
7. **How should the health care assistant approach the confused client?**
8. **How does the health care assistant cope with problem behaviors that result from confusion?**

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. **Have students break into groups of four or five and role play interactions between a confused client and members of the health care team.**
2. **View audiovisuals.**
3. **Have the class discuss ways a client may misinterpret his/her environment.**
4. **Have a class discussion on the stages of Alzheimer's.**
5. **Have students give reports from the manual, Confused Resident, from the Instructional Materials Laboratory.**

ANSWERS TO EVALUATION ITEMS:

1. d
2. a
3. b
4. g
5. c
6. f

7. e
8. d
9. b
10. d
11. c
12. b
13. c
14. d
15. F
16. T
17. F
18. T
19. F
20. F
21. T

LESSON PLAN: 64

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

___ 1. Agnosia

___ 2. Sundowning

___ 3. Dementia

___ 4. Apraxia

___ 5. Paranoia

___ 6. Aphasia

___ 7. Catastrophic reaction

a. Worsening of behavior problems occurs in the afternoon

b. Severe impairment of cognitive functions

c. Suspiciousness inappropriate to reality

d. Loss of ability to recognize familiar objects

e. Overreaction to circumstances

f. Loss of ability to use or understand language

g. Loss of ability to carry out planned movement at will

8. The definition of confusion is: (Circle the letter of the best answer.)

   a. Overreacting to circumstances.
   b. Sensory perceptions that seem real.
   c. Behavior problem that is worse in the evening.
   d. A state of being mixed up.

9. A common cause of confusion in the elderly is: (Circle the letter of the best answer.)

   a. Normal elimination habits.
   b. Depression.
   c. Sufficient oxygen to the brain.
   d. Contact with alert individuals.

10. Emotional and physical responses that may result from confusion include: (Circle the letter of the best answer.)

   a. Being rude, suspicious, and angry.
   b. Not responding to anything.
   c. Hallucinations.
   d. All of the above.

11. A behavioral response that may result from confusion is: (Circle the letter of the best answer.)

    a. Having one particular place to keep your purse.
    b. Checking the calendar daily for the date.
    c. Losing and misplacing items.
    d. Being able to do simple tasks of daily living.

12. Functional responses that may result from confusion are: (Circle the letter of the best answer.)

    a. Being independent and able to dress self.
    b. Unable to bathe, shower, or shave self.
    c. Continent of bowl and bladder.
    d. Feeding and dressing self with minimal assistance.

13. When approaching the confused client, the health care assistant should: (Circle the letter of the best answer.)

    a. Not bother explaining what the procedure is because they won't understand.
    b. Create an atmosphere of loud noises and a lot of activity.
    c. Treat the client with dignity and respect.
    d. Not touch the client and discourage group activities.

14. The health care assistant should cope with behavioral problems resulting from confusion by: (Circle the letter of the best answer.)

    a. Identifying the behavior.
    b. Determining the cause of behavior.
    c. Discuss with the other staff ways to handle and react to the behavior.
    d. All of the above.

For each of the following, write "T" if the statement is true, or "F" if it is false.

___ 15. If you treat the client like a child he/she will be happier.

___ 16. It is important to create a calm, orderly routine for the confused client.

___ 17. The confused client should not have a hearing aid as he/she may lose it.

___ 18. The physical needs of the confused client should be monitored.

___ 19. The confused client should not be encouraged to participate in activities outside his/her room since this may be upsetting.

___ 20. Never talk about the past with the confused client.

___ 21. When dealing with problem behaviors of the confused client, it is important to coordinate handling of the behavior and reaction to the behavior with others on the health care team.

HO 1

UNDERSTANDING MENTAL CONFUSION

About half of the long-term care population consists of clients who are confused, so it is important for health care assistants to understand confusion and how to care for these clients. The client who is confused may exhibit a deficiency in the following ways: memory of recent events, well-learned skills, and long-ago memories; loss of orientation to person, place, and time; language disturbance; visual and motor problems; problem solving and judgement.

> EXAMPLES: The ability to recall something that just happened may be lost but memories of childhood may be intact. Another category of memory has to do with well-learned tasks like driving, writing, dressing, and toileting. It is possible to lose just the ability to sequence the steps of an activity or the entire skill. Giving a verbal cue or demonstrating is helpful. Music is a memory that may remain intact when other skills are lost.

Orientation to person, place, and time may be lost selectively or altogether. A client may not recognize which room is his/hers but could recognize a roommate or nurse.

Language disturbance (aphasia) has two forms. It may be possible to produce speech and talk, but not understand what someone is saying although hearing is not affected. He/she may understand what is being said but is not able to respond with the correct words.

Visual problems (agnosia) is when someone sees but cannot figure out what the object is.

Motor problems (apraxia) is when someone wants to move as in picking up a spoon but just cannot do it.

The client who experiences loss tries to compensate; he or she may become emotionally upset, or become very frightened. There is a hierarchy of functions of the brain that is important to consider, for as the highest level becomes impaired, an individual may depend more on other levels of function. The simplest level is the automatic function like breathing or the heartbeat of which we are hardly aware. The next level is sensory awareness as in seeing, hearing, touching, hunger elimination, and orientation to sex. Higher up the complexity scale are instinctive behaviors which are genetically encoded like caring for others, self-defense, fear, finding shelter, etc. The most sophisticated level is abstraction and thinking, which is the first to be disturbed and is the most noticeable in confused clients. When clear thinking is lost, the client will depend to greater degree on the other levels of function.

It is important for the health care assistant to realize that the client may feel threatened and not understand what is happening in his/her environment. The health care assistant can communicate concern, acceptance, and reassurance. This can be done both verbally and nonverbally (facial expression, eye contact, body language, touch, tone of voice, etc.). The confused person often responds to nonverbal communication when memory and language fail. There are nursing care measures that will help to minimize the effects of confusion. The nursing goal is to maintain the client at the highest possible functional level for the longest amount of time.

HO 2

ALZHEIMER'S

I. Symptoms of Alzheimer's Disease (AD)

   A. Alzheimer's disease symptoms and progression present slowly; a gradual deterioration may go unnoticed, unlike some dementia which exhibit similar symptoms but have a sudden onset.

   B. Symptoms vary in clients; it can be compared to influenza in that some symptoms affect everyone, but how long a symptom lasts and how bad it is varies from individual to individual.

   C. Some clients progress quickly through the stages of Alzheimer's disease, while others may live for years without completely deteriorating.

   D. Common symptoms

      1. Gradual memory loss - Memory problems and decline in personal self-care may affect all clients. Other impairments may vary.

      2. Decline in ability to perform routine tasks

      3. Impairment of judgment

      4. Disorientation

      5. Personality changes

      6. Difficulty in learning

      7. Loss of language skills

II. Four Stages of Alzheimer's Disease - stages progress from a minor short-term memory loss to a complete loss of bowel and bladder function, memory, and speech; throughout all four stages there is steady mental and physical deterioration.

   A. First stage - behaviors exhibited in the first stage include:

      1. Difficulty focusing attention

      2. Decreasing interest in environment and present affairs

      3. Withdrawal from social interaction

      4. Uncertainty in actions

      5. Short-term memory loss

6. Typical symptoms associated with this stage of disease:
    a. Still living at home and functioning fairly well
    b. Beginning to have trouble driving
    c. Will have difficulty learning complex tasks
    d. Relocation to an acute care setting can make the client more confused and disoriented.
    e. Client must have instructions repeated several times and even written down on paper.

B. Stage two - behaviors/symptoms which are seen in the second stage of Alzheimer's disease include:
    1. Obvious deficits in memory
    2. Hesitation in verbal response
    3. Disorientation to time
    4. Complains of neglect
    5. Forgets appointments and significant events
    6. Forgets normal routines
    7. Behaviors/symptoms associated with this stage begin to present problems for the caregiver.
        a. Client may claim that no one has taken care of him/her that day, even though someone has.
        b. Client often loses money and personal belongings because he/she puts them in a "safe place" but then forgets where it is.
        c. Client may accuse caregivers of stealing misplaced items.

C. Third stage - involves greater mental deterioration; behaviors commonly seen in this stage include:
    1. Disorientation to place
    2. Wandering
    3. Disorientation to person
    4. Deterioration in motor ability

5. Immodesty

6. Communication difficulties (repeating words)

7. Compulsive acts of lip licking, chewing, tapping

8. Mirror signs (client does not recognize his/her own reflection)

9. Inability to read or write

10. Symptoms associated with this stage can be extremely difficult for caregivers to work with. Clients cannot function alone for many reasons related to safety issues; they need a great deal of assistance from the caregiver.

    a. Client may wander off and not be able to find the way back.

    b. Clients often refuse to carry out personal hygiene activities because they either think they have already completed them or the prospect of completing these tasks frightens them.

    c. Catastrophic reactions are common. This reaction is a sign that the client is overwhelmed.

    d. Routine activities of dressing, eating, and toileting become difficult, and the client needs more and more help in all activities.

    e. Deterioration continues until the client is totally dependent upon the caregiver.

D. Fourth stage - the terminal stage; life expectancy after reaching this stage is approximately one year.

1. Incontinence

2. Ataxia - loss of coordination

3. Visual hallucinations

4. Extreme psychomotor retardation

5. Inability to communicate or to recognize family members

6. Little or no response to stimuli

7. Susceptibility to infections

8. Marked weight loss

9. Alzheimer's disease clients in the fourth stage require total assistance and continual monitoring.

   a. Client loses the ability to eat and requires alternate feeding methods.

   b. Death usually results from complications due to immobility or respiratory infections.

III. Treatment of Alzheimer's Disease

A. No cure is available at the present time.

B. Good planning and medical and social management can ease the burden on the client and family.

C. Physical exercise and social activity are important as well as proper nutrition and health maintenance.

D. A calm and well-structured environment may help the afflicted person to maintain as much comfort and dignity as possible.

IV. Points to Remember When Caring for Alzheimer's Disease Clients

A. Speak in a normal tone of voice. Do not shout or whisper.

B. Ask questions that are short and to the point. Only ask one question at a time. When repeating a question, ask it exactly the same way as you did the first time.

C. Always get the client's attention before commenting or asking him/her a question. As soon as eye contact is made, begin speaking since the Alzheimer's disease client's attention span may only last a few seconds.

D. Use appropriate body gestures to help get your point across. But, be consistent with gestures. It will only add to the client's confusion if you use a gesture to mean one thing one time and something else at a different time.

E. The Alzheimer's disease client may take your actions or words as threatening; do not take it personally.

LESSON PLAN: 65

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

SCOPE OF UNIT:

This unit deals with the elderly individual. As a result of the aging process, significant changes occur in the human body. It is essential that the health care assistant be aware of the physical changes, mental changes, and social changes. We will discuss various health-related problems that you will encounter daily.

INFORMATION TOPIC: XVI-65 AND DEMONSTRATION: XVI-65

DEATH AND DYING
(Lesson Title)

OBJECTIVES - THE STUDENT WILL BE ABLE TO:

Information

1. Match terms presented in this lesson with their correct definitions.
2. Identify factors that affect a person's attitude about death.
3. Match the five stages of dying with the correct description.
4. Identify key points of psychological and spiritual needs of the dying client.
5. Identify specific physical changes associated with the dying process.
6. Identify nursing care measures to comfort the dying client.
7. Identify five signs of approaching death.
8. Identify key points in the care of the body after death.
9. Identify the health care assistant's feelings toward death.

Demonstration

10. Give postmortem care according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Perspectives on Dying, Program II, "Psychological Reactions of the Dying Person," filmstrip, Concept Media

2. Audiovisuals available from the Missouri Division of Aging Film Library
    a. Loss and Grief Series, filmstrip/cassette (TF #23), 61 min.
    b. The Lost Phoebe, video (TF #99), 25 min.
    c. The Middle of the End, video (TF #126), 29 min.
    d. Time to Cry, 16mm film (TF #42), 29 min.
    e. Dominick and Margaret, video (TF #116), 56 min.
    f. The Last Right, video (TF #75), 28 min.
    g. The Detour, video (TF #11), 16 min.
3. Projector
4. Television and VCR

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 65 (Student Reference page 997) prior to class and be prepared to discuss the information presented and return the demonstration on giving postmortem care.

REFERENCES:

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Anderson, Mary Anne; Karen Beaver; Ruth Wheeler. The Long Term Care Nursing Assistant Training Manual. 1st ed. Baltimore, MD: Health Professional Press, 1991. Chapter 39.

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Kübler-Ross, Elisabeth. On Death and Dying. New York, NY: McMillan Publishing Co., 1969.

Will, Connie; Judith Eighmy. Being a Long Term Care Nurse Assistant. 2nd ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1988. Chapter 3.

Witmer, Dorothy. Geriatric Nurse Assistant Advanced Training in Selected Competencies. 1st ed. Englewood Cliffs, NJ: A Brady Book, Prentice Hall, 1990. Chapter 12.

INTRODUCTION:

Caring for a dying client can be one of the greatest challenges of a health care worker. Even though we are well aware that all life must end in death, we tend to avoid thinking about this until we are actually faced with the situation. Today's life span has been still the last learning experience. It is very important that you, as a nurse assistant, work through your own feelings about death so that you can comfort and assist the dying client and his/her family.

Death can occur at any time from the first few hours of life until the individual is very advanced in age.

This lesson will assist you in identifying the stages that a client and/or the family faced with a terminal illness may go through. We will also discuss the psychological, spiritual and physical needs of the dying client and how to determine when a client is near death.

LESSON PLAN: 65

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

OUTLINE:

I. Terms and Definitions **(II-1)**

A. Death - permanent stoppage of all vital functions of the body

B. Hospice - a type of care that provides comfort for terminally ill persons

C. Postmortem - after death

D. Rigor mortis - temporary rigidity of muscles of the body occurring after death

II. Factors Affecting Attitudes About Death **(II-2)**

A. Personal experience

B. Culture

C. Religion

D. Age

III. Five Stages of Dying (as identified by Elisabeth Kübler-Ross[1]) **(II-3)**

It is desirable for a dying client to progress through the five stages of dying. A client may never get beyond a certain state or he/she may move back and forth between stages. Some clients remain in one stage until death. They may never reach acceptance. The client's family may also experience the same stages of mourning that the client is going through.

A. Denial

1. Individual refuses to believe he/she is dying. The person thinks, "No, not me."

2. The health care assistant needs to be available to the client; allow him/her to deny impending death. Just listen.

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[1] Kübler-Ross, Elisabeth. On Death and Dying. New York, NY: McMillan Publishing Co., 1969.

B. Anger

1. Individual is envious and resentful of those who have life and health; it is directed at those around him/her; the person thinks, "Why me?"

2. The health care assistant must accept the anger if it is in an acceptable form. Realize it is not directed at you.

C. Bargaining

1. Individual tries to gain more time; usually done with God; the person thinks, "Yes, me, but..."

2. They may want to live until a certain event occurs.

3. The health care assistant should understand the client is trying to buy more time; he/she is beginning to accept the reality of his/her fate.

D. Depression

1. Individual is very sad and mourns over things he/she will never do; the person thinks, "Yes, me."

2. Individual feels sad because he/she is leaving loved ones.

3. The health care assistant should not try to cheer up the client. Realize that the client is mourning.

E. Acceptance

1. Individual experiences peace and calm; is ready to accept death. Reaching this state of acceptance does not mean that the time of death is near. Many elderly clients have reached this point.

2. The health care assistant should assure the client that he/she will be given the best nursing care possible.

3. Resignation - not a true acceptance; giving up

IV. Psychological and Spiritual Needs **(II-4)**

A. The health care assistant needs to use two important aspects of communication when dealing with the dying client.

1. Listening - the client is the one who needs to talk; may be encouraged to discuss his/her feelings, concerns and worries by the presence of one who will listen

2. Touch - conveys caring and concern to the client when words cannot; reaffirms the client's humanness

B. The health care assistant must respect the client's spiritual needs.

  1. Assist in obtaining spiritual guidance for the client who may wish to see a priest, rabbi, or minister.

  2. Provide privacy during spiritual moments and show courtesy when clergy visits.

  3. Assistance in obtaining spiritual support may be needed by the family at the immediate time of death.

V. Physical Changes

A. The process of dying may involve a few minutes/hours or it may take days or weeks. There is a general slowing down of body functions and changes in the level of consciousness.

B. Specific changes **(II-5)**

  1. Vision becomes blurred and gradually fails; increased amounts of secretions accumulate in the corners of the eyes.

  2. Speech becomes more difficult.

  3. Hearing is one of the last senses and functions to be lost.

  4. Mucus may accumulate in the mouth as the client is unable to swallow.

  5. Urinary and stool incontinence may develop or urinary retention and constipation.

VI. Nursing Care Measures to Comfort the Dying Client **(II-6)**

A. Room should be well-lighted, but bright lights and glare should be avoided.

B. Give good eye care.

C. Even though it may be difficult for the client to speak, you should still talk to him/her; ask questions so he/she can answer with a simple yes or no.

D. Speak in a normal voice--do not whisper; keep in mind that the client may still be able to hear. Do not say things that you would not want the client to hear. Offer reassurance and give explanations.

E. Oral hygiene is very important.

F. Give good peri care; keep client clean and dry.

G. Good skin care and frequent position changes; good body alignment and supportive devices will help client feel more comfortable.

H. Report to charge nurse if client appears to be in pain or complains of pain.

VII. Signs of Death **(II-7)**

A. Eyes have a glossy appearance, stare into space.

B. Movement, muscle tone, and sensation are lost.

C. Peristalsis slows down, noted by abdominal distention, incontinence, impaction, nausea, and vomiting.

D. Circulation fails and body temperature rises. Client's legs and feet feel cool, client may appear pale and perspire heavily. Arms and legs become cyanotic/mottled.

E. Pulse is fast, weak, and irregular; BP begins to fall.

F. Respirations fail - become very slow; Cheyne-Stokes; or rapid and shallow.

G. Mucus collects in the client's throat causing a sound called the "death rattle."

H. Level of consciousness varies--from drowsy, stupor (may still be aroused), to coma (loss of consciousness). Some people do not lose consciousness until the moment of death.

I. The client is pronounced dead when there is absence of a pulse, respirations, and blood pressure. The pupils are fixed and dilated.

VIII. Care of the Body After Death **(II-8)**

A. Use the facility's procedure.

B. Proper care is needed after death to maintain good appearance of the body and prevent damage to the skin.

C. Treat the body with respect.

D. Rigor mortis is the stiffness or rigidity of skeletal muscles that occurs after death; it will occur within two to four hours after death.

E. Elevate the head of bed slightly to prevent discoloration of face.

F. Close the eyes, remove the equipment, bathe soiled parts, replace soiled dressings, and put dentures in labeled container.

G. Valuables and personal possessions should be given to the charge nurse who will give them to the family. Entry must be made in the chart.

H. Cover the body to the shoulders with a sheet if the family is to view the body.

I. Provide privacy for family when they visit.

IX. The Health care assistant's Feelings Toward Death (II-9)

A. Learn to express feeling to someone (friends, family, coworker)

B. Realize you are a person with emotions and feelings--it is okay to feel sad when someone you care about dies. It is okay to cry.

C. No one has the answer to how to deal with death--it is an experience of which we are unsure of the outcome.

X. Demonstrate Procedure for Giving Postmortem Care.

XI. Summary and Conclusion

A. Terms and definitions

B. Factors affecting attitudes about death

C. Five stages of dying

D. Psychological and spiritual needs

E. Physical changes

F. Nursing care measures to comfort the dying client

G. Signs of death

H. Care of the body after death

I. The health care assistant's feelings toward death and dying

J. Review the procedure for giving postmortem care.

As a health care assistant, you will provide care to many clients throughout the final stage of life. Death is the final stage of the life cycle and a part that none of us can evade. Accepting this fact may help you deal with your own feelings and the feelings of the client and his/her family.

LESSON PLAN: 65

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

STEPS OF PROCEDURE FOR POSTMORTEM CARE:

1. Wash hands. Put on gloves.
2. Flatten bed and straighten the body.
3. Elevate head of bed slightly.
4. Close eyes by gently holding in place a few moments.
5. Place dentures in cup.
6. Cleanse the body.
7. Comb hair.
8. Cover client with clean linen up to chin.
9. Arrange linen neatly.
10. Straighten room and medical equipment.
11. Provide privacy for family.
12. Remove gloves and dispose in appropriate container. Wash hands.
13. Take jewelry and belongings to charge nurse.

LESSON PLAN: 65

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

INTERACTION ITEMS:

1. How do you define death, postmortem, and rigor mortis?
2. What four factors affect our attitudes about death?
3. What are the five stages of dying?
4. How can the health care assistant meet the psychological and spiritual needs of the dying client?
5. What physical changes occur during the process of dying?
6. How can the health care assistant comfort the dying client?
7. What are five signs of death?
8. How do you care for the body after death?
9. What are three ways in which the health care assistant can cope with his/her feelings about death?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students write down their feelings about death by answering these questions:
    a. If you only had one more day to live, how would you spend it?
    b. Where would you rather die, in a hospital, nursing home, or at home?
    c. How does the age of a person affect your feelings about death?
2. Instructor should demonstrate postmortem care.
3. Students should complete the postmortem care procedure in lab.
4. Discuss how students would expect a dying relative to be treated.
5. Show audiovisuals.
6. Discuss how you would feel if you were the last living individual of your family.

ANSWERS TO EVALUATION ITEMS:

1. c
2. d
3. b
4. a
5. d
6. c
7. d
8. b
9. e
10. a
11. d
12. c
13. a
14. d
15. b
16. c

LESSON PLAN: 65

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

EVALUATION ITEMS:

Match the term in Column I with the correct definition in Column II.

Column I	Column II
____ 1. Rigor mortis	a. Permanent stoppage of all vital functions of the body
____ 2. Hospice	b. After death
____ 3. Postmortem	c. Temporary rigidity of muscles of the body occurring after death
____ 4. Death	d. A type of care that provides comfort for terminally ill persons

5. Factors that affect a person's attitude about death are: (Circle the letter of the best answer.)

   a. Culture
   b. Age
   c. Religion
   d. All of the above

Match the stage of death in Column I with the correct description in Column II.

Column I	Column II
____ 6. Anger	a. The person refuses to believe he/she is dying.
____ 7. Depression	b. The person is ready to accept death and is peaceful and calm.
____ 8. Acceptance	c. The person is resentful of those who have life and health.
____ 9. Bargaining	d. The person is very sad and moans over things he/she will never do.
____ 10. Denial	e. The individual tries to gain more time.

11. When caring for the dying client, the health care assistant can best meet his/her psychological and spiritual needs by: (Circle the letter of the best answer.)

    a. Calling the minister from the health care assistant's church to talk with the client.
    b. Spending as little time as possible in the client's room.
    c. Telling the client that his/her life is out of your hands.
    d. Holding the client's hand and listening when he/she talks about feelings and worries.

12. What are physical changes as death approaches? (Circle the letter of the best answer.)

    a. Speech is clear and precise.
    b. Swallowing is continuous.
    c. Urinary retention and constipation may occur.
    d. Hearing is the first sense and function to be lost.

13. Mrs. Whitt is your assigned client. Mrs. Whitt is dying. Her daughter has come a long distance to be with her. While providing nursing care to Mrs. Whitt, you should provide which one of the following nursing measures to comfort her? (Circle the letter of the best answer.)

    a. Speak in a normal voice when talking to Mrs. Whitt and her daughter and allow the daughter to stay with her mother.
    b. Whisper to Mrs. Whitt's daughter that she will not be able to stay in the room with her mother because it would disturb the other client in the room.
    c. Keep the room dimly lighted and do not talk to Mrs. Whitt as you provide care.
    d. Tell the daughter that her mother doesn't know she is there and she should leave.

14. Signs of approaching death are: (Circle the letter of the best answer.)

    a. Legs and feet feel cool to the touch and become cyanotic/mottled.
    b. Pulse is fast, weak, and irregular, blood pressure falls.
    c. Mucus collects in the client's throat causing a sound called the death rattle.
    d. All of the above.

15. When caring for the body after death, the health care assistant should: (Circle the letter of the best answer.)

    a. Give valuables and personal possessions to the family.
    b. Elevate the head of the bed slightly to prevent discoloration of the face.
    c. Stay with the family when they visit and cover the head.
    d. Remember that rigor mortis occurs immediately after death.

16. You have become very fond of Mr. Zimmerman as you cared for him before death. After Mr. Zimmerman dies, you feel very sad. Which one of the following actions would be most appropriate for handling your feelings of sadness?

a. Do not let your co-workers know how you feel.
b. Control your feelings and above all do not cry.
c. Realize it is okay to feel sad and shed some tears.
d. Ask to have the rest of the day off.

LESSON PLAN: 65

COURSE TITLE: HEALTH CARE ASSISTANT

UNIT XVI : UNDERSTANDING THE ELDERLY

EVALUATION ITEMS: NAME OF STUDENT: ______________

GIVE POSTMORTEM CARE

Equipment:

1. Washcloth
2. Soap
3. Client's comb
4. Clean linen

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. Put on gloves.		
2. Flatten bed and straighten the body.		
3. Elevate head of bed slightly.		
4. Close eyes by gently holding in place a few moments.		
5. Place dentures in cup.		
6. Cleanse the body.		
7. Comb hair.		
8. Cover client with clean linen up to chin.		
9. Arrange linen neatly.		
10. Straighten room and medical equipment.		
11. Provide privacy for family.		
12. Remove gloves and dispose in appropriate container. Wash hands.		
13. Take jewelry and belongings to charge nurse.		

The student has satisfactorily completed the procedure "GIVE POSTMORTEM CARE" according to the steps outlined.

______________________________ ______________

Instructor's/Approved Clinical Supervisor's Signature Date
(Verifying Satisfactory Completion)

GLOSSARY

Abandonment - leaving client unattended

Abdominal respiration - uses mostly the abdominal muscles to breath

Abduction - movement away from midline of body

Abrasion - a scraping or rubbing off of the skin

Absorption - passing of a substance into body fluids and tissues

Abuse - the infliction of physical, sexual, or emotional injury or harm

Acetone - ketone bodies that appear in the urine

Active immunity - that acquired by producing one's own antibody

Active range of motion exercises - movements carried out by the client

Activities of daily living - activities we do each day such as brushing our teeth, washing our face, taking a bath, dressing, etc.

Acute - rapid onset with pronounced symptoms and lasting a short time

Acute care facility - hospitals and clinics for immediate, short-term care

Adduction - movement of part of body toward midline of body

Adipose capsule - a mass of fat tissue that encloses each kidney and its blood vessels

Aerobic organism - a microorganism that requires oxygen in order to live

Afebrile - without fever

Afferent nerve - carries nerve impulses from the periphery to the central nervous system; a sensory nerve

Agnosia - loss of the ability to recognize familiar objects

AIDS - acquired immunodeficiency syndrome: a condition characterized by the collapse of the body's natural immunity against disease

Ailment - latin term meaning food

Albuminuria - presence of serum albumin in the urine

Alimentary canal - also known as the digestive tract and gastrointestinal tract

Alzheimer's - a form of dementia that begins slowly, with an inability to name familiar objects

Ambulatory - able to walk

Amniotic sac - shock absorbing sac filled with fluid which surrounds the embryo

Amphiarthrosis - partially moveable joint

Anaerobic organism - a microorganism that can exist only in the absence of air

Analgesic - pertaining to the giving of a medicine to remove or relieve pain

Anatomy - the study of the shape and structure of the body

Anemia - red blood cell count drops below normal

Aneurysm - blood-filled, saclike dilation of the wall of an artery

Angina - any disease characterized by spasmodic suffocative attacks

Angiology - study of the circulatory system

Ankylosis - complete immobility of bones

Anorexia - loss of appetite

Antagonist pair - when a pair of body muscles produce movement in opposite directions

Anterior - toward the front

Antibiotic - a substance lethal to bacteria; drug used to destroy bacterial diseases

Antigen - a substance that stimulates the body to make antibodies

Antiperspirant - a skin care product that reduces the amount of perspiration

Antiseptic - an agent which prevents infections in living tissues

Anuria - diminution of urinary secretions to 100 cc or less in 24 hours

Anus - outlet of the rectum

Aorta - largest artery in body, rising from left ventricle of the heart; carries oxygenated blood to all parts of the body

Aortic-semilunar valve - consists of three half-moon shaped cups; located between junction of aorta and left ventricle of heart

Apex - pointed end of a conical structure

Aphasia - language difficulty, due to brain damage, which can affect listening, speaking, reading, and writing skills

Apnea - breathing stops temporarily

Appendicular muscle group - extremity muscles

Approach - a way or ways to reach the goal

Apraxia - loss of the ability to carry out planned movement at will

Arteriole - small branch of an artery

Arteriosclerosis - hardening of the arteries

Artery - blood vessel that carries blood away from the heart

Arthritis - inflammation of a joint

Arthrology - study of joints

Asepsis - the absence of germs

Aseptic - free of microorganisms

Aspiration - to draw food or other objects into lungs

Assault - threat or attempt to injure another in an unlawful manner

Assessment - an appraisal of the whole person to establish a baseline and determine the client's potential and his need for help

Asymptomatic - show no signs or symptoms of infection.

Atlas - first cervical vertebra

Atrial fibrillation - rapid, irregular rhythm, and intensity of the heart beat; irregular atrial impulses and ineffective atrial contractions

Atrioventricular valves - tricuspid and mitral (bicuspid) valves of the heart

Atrium - heart's upper chambers

Atrophy - wasting away of tissue (muscle shrinkage)

Autoclave - equipment used to sterilize material and equipment in a health care facility

Axial muscle group - the head, face, neck, and trunk muscles

Axilla - armpit

Axis - second cervical vertebra

Axon - structure of a nerve cell that carries impulses away from the cell body to the dendrites

Bacteriology - study of bacteria

Ball and socket joint - one bone has a ball-shaped head which nestles into a concave socket of the second bone.

Battery - unlawful application of force to the person of another

Biology - the study of all forms of life

Bisexual - homosexual and heterosexual relations

Bladder - a muscular sac that stores the urine in the body

Blood pressure - the amount of force exerted against the walls of an artery by the blood

Body temperature - the amount of heat in the body that is a balance between the amount of heat produced and the amount lost by the body

Bone fracture - any break of bone

Brachycephalic artery - located on the right side of aortic arch; divided into the right subclavian and right common carotid arteries

Bradycardia - abnormally slow heart beat; below 60 beats per minute

Bronchiectasis - dilatation of the bronchi

Bronchitis - inflammation of the bronchi

Bronchoscopy - inspection or examination of the bronchi

Bursa - *joint capsule*

Capillary - blood vessel that connects arterioles with venules, microscopic in size

Cardiac - pertaining to the heart

Cardiac muscle - muscle of the heart

Cardiac arrest - heart fails to pump blood

Cardiac arrhythmia - change in the normal rhythm and beat of the heart

Cardiologist - a specialist in treating disorders of the heart

Cardiology - the science and study of the heart

Cell - a definite unit in the organization of living substance, consisting of a small mass of protoplasm with a nucleus and surrounded by a membrane (the plasma, or cell, membrane)

Cardiopulmonary resuscitation - the procedure for maintaining respiration and heart beat by manual means when breathing and heart beats have stopped

Care plan - an individual plan of care for each client

Caries - tooth decay

Carotid artery - supplies blood to the neck and head

Carrier - a person who is not infected but transports harmful pathogens

Cartilage - tough, strong tissue; found in nose, ears, and at the ends of bones

Catastrophic reaction - overreaction to circumstances

Catheter - a sterile tube inserted into bladder to drain urine

Catheterization - the process of inserting a catheter

Cephalalgia - headache

Certified bed - beds in a skilled or intermediate care facility that are licensed for medicaid clients

Characteristics - irritability, motility, metabolism, growth, and reproduction

Chart - the client's record

Cheyne-Stokes - a pattern of breathing in which respirations gradually increase in rate and depth and then become shallow and slow; breathing may stop for 10 to 20 seconds

Cholecystectomy - excision or removal of the gallbladder

Cholecystitis - inflammation of the gallbladder

Chronic - continuing over a long period of time or recurring frequently; chronic conditions begin insidiously, and symptoms are not as noticeable as in acute conditions

Circumcised - surgical removal of the end of the foreskin of the penis

Clean - an area or object which is not contaminated by microorganisms

Clean-catch - collection of urine specimen that is not contaminated by anything outside the client's body

Client - someone who pays a professional for services; can be a patient or resident

Coitus - sexual intercourse

Communicable disease - a disease which can be naturally transmitted from one individual to another by direct or indirect contact

Communication - the exchange of information accomplished by sending and receiving messages, resulting in understanding between the sender and the receiver

Composition - 70% water, calcium, phosphorus, etc.

Conduct - one's actions in general; behavior

Conductivity - ability to transmit to distant points

Confused - state of being mixed up

Confusion - a mental state characterized by disorientation regarding time, place, or person

Consent - permission granted voluntarily by a person in his/her (sound/clear) mind

Constipation - difficult or infrequent movement of the bowels

Constrict - get smaller

Constructive criticism - criticism offered in a way that is acceptable and helpful

Contact guarding - client requires hand contact because of occasional loss of balance (protective safeguard)

Contaminated - unclean; soiled; exposed to germs

Contamination - the presence of material which is capable of causing an infection

Contractibility - muscle's ability to shorten or contract

Contracture - when muscle tissue becomes shortened because of spasm or paralysis, either permanently or temporarily

Contusion - an injury that does not break the skin, caused by a blow to the body and characterized by swelling, discoloration, and pain

Coronary - refers to the blood vessels of the heart

Criticize - to find fault with someone or something

Cryptorchidism - undescended testes

Cyanosis - bluish discoloration of the skin

Cyanotic - a bluish-gray color of the skin, lips, or nail beds due to lack of oxygen

Cytology - the study of cells, their origin, structure, and functions

Data collection - the act of collecting as much information as possible

Daydream - to let the mind wander

Death - permanent stoppage of all vital functions of the body

Defecation - elimination of waste material from the rectum; passing of stool

Deglutition - swallowing

Dehydration - loss of body's normal water content, which can affect both physical and mental functions

Dementia - severe impairment of cognitive functions such as thinking, memory, and personality

Dendrites - a process of the nerve cell that carries impulses toward the cell body

Dentures - artificial teeth which replace all or part of a person's teeth

Deodorant - controls and masks body odor

Dermal - of or pertaining to the skin

Dermatitis - inflammation of the skin

Dermatologist - specialist in the diagnosis and treatment of skin diseases

Dermatology - study of skin, hair, and nails

Dermatomycosis - any fungal disease of the skin

Dermatosis - any generalized skin disease

Diagnosis - determining what kind of disease or medical condition a person has; the health care assistant can find out by looking in the chart; the doctor determines the problem based on tests, observations, etc.

Diaphoresis - excessive sweating

Diaphragm - dome-shaped muscle separating the thoracic and abdominal cavities

Diarrhea - frequent passage of liquid stool

Diarthrosis - moveable joint

Diastole - the dilation stage of the cardiac cycle

Diastole - relaxation phase of heart contraction

Diastolic blood pressure - the force when the ventricles are relaxed

Diastolic pressure - the pressure in the arteries when the heart is at rest

Diffusion - movement of particles through a cell membrane, either in or out, when their concentration is greater on one side of the membrane than on the other

Digestion - the process of changing complex solid foods into simpler soluble forms which can be absorbed by the body cells

Dilate - to expand or open wider

Dipsosis - a condition producing thirst

Dirty - an area or object which is contaminated by harmful microorganisms

Disinfection - a process that destroys most pathogenic microorganisms on inanimate objects

Disorientation - the state of mental confusion or loss of bearings in relation to the sense of person, place, or time

Distention - state of being inflated, enlarged, or stretched out

Distractions - actions or noises around an individual that make it difficult for him/her to pay attention

Dry application - water is not in contact with the skin

Ductless gland - a gland that secretes hormones directly into the blood stream; (an endocrine gland)

Dysphagia - difficulty swallowing

Dyspnea - painful, difficult, labored breathing

Dysuria - painful urination

Ectopic pregnancy - ovum slips into the abdominal cavity and becomes fertilized there

Edema - swelling due to an accumulation of watery fluid in the tissue

Ejaculation - expulsion of semen from the penis

Elasticity - ability of muscle to return to its original length when relaxing

Elimination - to rid the body of wastes, such as urine or stool

Embryo - the fetus the first three months after conception

Emergency - an event that calls for immediate action

Emesis - vomiting

Emotion - one's feelings

Empathy - identification with, and understanding of, another's situation, feelings, or motives

Encephalitis - inflammation of the brain

Endocardium - membrane which lines interior of heart

Endocrine gland - an organized group of tissues that use materials from the blood or lymph to produce hormones

Endocrinology - study of the endocrine (hormonal) system

Endothelium - epithelial cells; they line closed body cavities, blood vessels, and heart and lymph vessels

Enteritis - inflammation of the intestine

Enteron - means intestine

Enzymes - proteins which act as chemical catalysts in living organisms that initiates and accelerates a chemical reaction

Epidemiology - study of relationship of factors determining frequency and distribution of disease

Erythroblast - an immature red cell

Erythrocyte - a red blood cell

Ethical - relating to a set of moral principles and values

Ethics - the discipline dealing with that which is good and bad and that which is moral duty and obligation

Eupnea - normal breathing

Eversion - a turning outward

Exocrine or duct gland - a gland that discharges its secretions into ducts; are not endocrine glands

Exploitation - illegal or improper use of a person's property or resources to the degree that substantial risk of harm exists

Extensibility - muscle's ability to be stretched

Extension - to straighten; making angle at joint larger

Extrapulmonary - refers to tuberculosis outside the lungs

Extremities - the arms, legs, hands, and feet

False imprisonment - unjustified detention of a person

Fatigue - extreme tiredness

Febrile - feverish

Feces - waste products of digested food discharged from the intestine (stool, BM)

Feedback - the return of a portion of the information sent; a reply that shows the message was received

Fetus - from third month of intrauterine period until birth

Fever - elevation of body temperature above normal

Fibrosis - fibrous tissue formation

Filtration - movement of particles in solution from a place of higher hydrostatic pressure to a place of lower hydrostatic pressure

Fissure - deep groves of a structure; clefts

Flatus - gas in the bowel

Flexion - making angle at joint smaller; to bend joint

Flow rate - the rate which IV solution enters the body; measured in drops per minute

Flushed - reddened color of the skin

Foley catheter - a catheter that is left in the urinary bladder so that urine drains continuously into a bag

Fomites - inanimate objects contaminated by infected persons

Foreskin - loose skin at and covering the end of the penis

Ganglia - a group of cell bodies outside the central nervous system that carry impulses to involuntary muscles and glands

Gangrene - death of tissue usually due to deficient or absent blood supply

Gastero - greek term meaning food

Gastritis - inflammation of the stomach

Gastroenterology - study of the stomach and intestines and their diseases

Gastrostomy tube - a tube inserted through the abdominal wall into the stomach

Gavage - tube feeding

Genital area - the area which includes the external sex organs and the anus

Germ - microorganism

Gland - any organ that produces a secretion

Gliding joints - those in which nearly flat surfaces glide across each other; Ex. vertebrae of the spine

Glycosuria - sugar in the urine

Goal - the desired end result, what one hopes to accomplish

Graduate - a container marked with lines for measuring liquids (HO 1)

Gram positive or gram negative bacteria - denotes color the bacteria take when a special stain is used

Gray matter - matter that contains naked nerve fibers

Gynecologist - specialist in treating female disorders

Gynecology - the branch of medicine treating diseases of women

Halitosis - bad breath

Hallucination - sensory perceptions that seem real to the person experiencing them but are not perceived by others

Hazard - a source of potential danger

Health care facility - any facility designed for individuals requiring health care

Hematocrit - the volume percentage of red cells to the whole blood (separation of red cells for counting)

Hematuria - presence of blood in the urine

Hemoglobin - iron-containing protein in red blood cells

Hemoptysis - coughing up blood

Hemorrhage - excessive, uncontrolled bleeding

Hepatic - of or pertaining to the liver

Hepatitis - inflammation of the liver

Heterosexual - characterized by sexual attraction felt by a person for another person of the opposite sex

Hinge joints - move in two directions: flexion and extension; Ex. knee and elbow

Histocyte - a tissue cell

Histology - the study of tissue

HIV - means human immunodeficiency virus

Home health agency - agency that provides extended care in the home

Homeostasis - a state of chemical balance between a cell and its environment

Homosexual - characterized by sexual attraction felt by a person for another person of the same sex

Hormones - protein substance secreted by endocrine glands directly into the blood stream; circulated to another part of the body where it stimulates increased activity by chemical action

Hospice - care of persons during a terminal illness; either in the home or a health care facility

Hospital - a facility which provides care for clients of all ages with varied health problems

Host - person, animal, or plant which supports a parasite

Hot soak - putting the body part into a container of water

Hydrostatic pressure - pressure exerted by a liquid within a closed system

Hygiene - clean and sanitary

Hyperextension - extensive extension

Hyperpnea - abnormal increase in depth and rate of respirations

Hypertension - high blood pressure; persistent BP measurements above the normal systolic (150 mm Hg) or diastolic (90 mm Hg) pressures

Hypotension - low blood pressure; condition in which systolic BP is below 100 mm Hg and diastolic pressure is below 60 mm Hg

Hypoxia - oxygen deficiency

Hysterectomy - removal or excision of the uterus

Ice bag - a dry cold application

Iliac - pertaining to the ilium

Ileitis - inflammation of the ileum

Immobile - unable to move

Immune deficiency - a lack of immune bodies and resultant impairment of the immune response to foreign agents (e.g., the body doesn't have enough white blood cells to fight off a disease or infection)

Immunity - resistance to a specific disease

Impaction - hard stool that cannot pass from the rectum normally

Impairment - that which hinders proper function

Implementation - carrying out a plan of action

Incident - an unusual event or occurrence

Inclusion bodies - colonies of viruses growing in tissues

Incontinent - inability to control evacuation of one's bowels or bladder or both

Incubation period - period between the entrance of the organisms to the body and beginning of symptoms

Independent - client requires no assistance; performs activity safely alone and feels secure

Infection - invasion of the body by a disease-producing (pathogenic) organism; these agents subsequently multiply and damage tissues

Inflammation - reaction of tissue to injury of any kind

Infusion site - where the IV needle is inserted

Insertion - part of the muscle attached to a moveable bone or fixed structure

Intermediate care facility - facility with a director that is an RN or LPN; if the director is an LPN, the facility must have an RN consultant a minimum of four hours per week; if a level II facility, an LPN or RN must also be on the day shift; LPN or RN must be on call 24 hours per day

Interstitial fluid - intercellular connective tissue fluid

Intravenous infusion (IV) - nutrients are given through the vein

Invasion of privacy - a civil wrong that unlawfully makes public knowledge of any private or personal information without the consent of the wronged person

Inversion - a turning inward

Iritis - inflammation of the iris

Irregular respirations - the depth of breathing changes and the rate of the rise and fall of the chest is not steady

Irritability - react when stimulated

Isolation technique - special procedures to prevent the spread of harmful microorganisms

Itis - means inflammation of a part

IV - refers to intravenous fluids

Jargon - specialized or technical language of a trade, a profession, or a group of people

Jaundice - yellow discoloration of skin due to bile

Joint - place where two bones meet

Kardex - a card file with a summary of information found in the client's chart

Ketone body - acids produced during fat catabolism

Kidneys - filtering system of the body

Labia - the skin folds which are on both sides of the urethra and vagina

Laceration - wound produced by cutting or tearing

Laryngitis - inflammation of the larynx

Lateral - to the side

Legal - relating to the law

Leukemia - malignant (cancer) disease which has with a large increase in the number of white cells

Leukocytes - white blood cells whose chief function is to protect the body against pathogenic microorganisms

Leukopenia - abnormally low white blood cell count

Libel - a false and malicious publication in writing about an individual or group to a third party

Licensed facility - a facility that has met the requirements of the Division of Aging for licensure

Licensed bed - beds for private pay individuals in licensed facilities

Ligament - sheet of tough tissue that holds bones together at the joint

Listen - to pay attention in order to hear

Local heat application - heat is applied to a body part

Locomotion - act of moving from place to place

Logy - means study of

Long-term care facility - facility designed for care of clients for an extended period of time

Lymph nodes - small nodules of specialized immune cells located throughout the body (also called lymph glands or glands)

Lymphocytes - a type of white blood cell; formed in lymphoid tissue and important in the development of immunity

Malpractice - improper or negligent treatment of a client resulting in damage or injury

Mantoux tuberculin skin test - tuberculin test given by injecting 0.1 ml of PPD-tuberculin into the superficial layers of the skin (usually in the forearm) with a needle and syringe; the most reliable and best standardized technique for tuberculin testing

Mastectomy - excision of the breast

Mastication - process of chewing

Mastoplasty - plastic surgery on the breast

Maximal assist - client contributes little or nothing toward execution of activity, is totally dependent

Medicaid - a program funded by the federal and state governments for individuals whose income are below a certain level; it pays for medical costs

Medical asepsis - protection of clients and personnel from infection or reinfection (clean technique)

Medicare - a federal program that assists with medical costs for individuals over the age of 65

Melanuria - black or dark discoloration of the urine

Menarche - beginning of menses

Metabolism - sum total of chemical reactions which occur in a living organism

Metazoa - multicellular animal forms, e.g., roundworms, tapeworms

Metrorrhagia - uterine bleeding

Micro - means small

Microbiology - the scientific study of microorganisms

Microorganism - a very small living thing (a germ) which can only be seen with a microscope

Micturition - voiding or urination

Midstream - collecting the urine specimen between the time the client begins to void and the time he/she stops

Milliliter (ml) - same as cubic centimeter (cc)

Minimal assist - client requires a small amount of help to accomplish activity

Mobility - ability to move

Moderate assist - client definitely requires help, but contributes half the effort

Moist application - water is in contact with the skin

Monogamous - having only one mate

Morals - your own personal values

Mucosa - mucous membrane

Mucus - the slippery secretions of the mucous membrane, composed of mucin, various salts, and body cells; mainly in the lungs, nose, and parts of the rectal and genital areas

Muscle tone - muscles in good health are slightly contracted and ready to work.

Muscle fatigue - accumulation of lactic acid in the muscle

Mutation - changing of form to a new variety. A cell form changes from normal to abnormal.

Myalgia - muscle pain

Myasthenia - weakness of the muscle

Mycobacterium tuberculosis - the bacterium which causes TB; often abbreviated *M. tuberculosis*

Myocardial - pertaining to the muscular tissue of the heart

Myocardium - heart muscle

Myology - study of the muscular system

Nasal - pertaining to the nose

Nasogastric tube - a tube which is inserted through the nose and down into the stomach; commercial formulas are given through the tube

Nasoscope - a lighted instrument to examine the nose

Nasoseptal - pertaining to the nasal septum

Necrotic - the change that occurs as a result of the death of cells

Need - something essential or desirable that one is lacking or something one feels is lacking

Neglect - failure of person(s) responsible for an individual to provide necessary services to maintain the physical and mental health of the individual, when such failure presents an imminent or probable danger to the individual

Negligence - failure to perform in a reasonably prudent manner or by acceptable health care practices

Neuralgia - painful nerves, nerve pain

Neuritis - inflammation of a nerve

Neurology - study of the nervous system

Nocturia - excessive urination at night

Nonverbal communication - messages sent and received through gestures, facial expressions, posture, and dress/appearance

Nosocomial - an infection acquired while in a health care facility

Nursing process - a problem-solving technique that consists of six steps: 1) data collection, 2) assessment, 3) problem identification/diagnosis, 4) planning, set goals and approaches to reach the goals, 5) implementation, and 6) evaluation

Nursing care plan - a written guide that gives directions about the nursing care a client must receive

Nutrient - food that supplies the body with its necessary elements

Nutrition - the process whereby the body takes in food and produces energy for growth and repair

Obese - extremely fat

Objective data - information and symptoms that the health care assistant can see, hear, feel, and smell

Observation - collection of information about the client by seeing, hearing, touching, and smelling

Obstruction - a blockage

Oliguria - diminution of urinary secretions to between 100 and 400 cc in 24 hours

Oophorectomy - excision or surgical removal of an ovary

Oophoritis - inflammation of an ovary

Opaque - cloudy; light is unable to pass through

Ophthalmology - study or science of what is known of the eye and its structure

Ophthalmoscope - an instrument to examine the eye

Oral - pertains to the mouth

Oral hygiene - care of the mouth, teeth, and gums

Orgasm - the climax of coitus

Origin - part of skeletal muscle that is attached to a fixed structure or bone

Orthopnea - able to breath only in upright position

OSHA - signifies the Occupational Safety and Health Administration

Osmosis - movement of solvent molecules through a semipermeable membrane from region of higher water concentration to lower concentration

Osteitis - inflammation of a bone

Osteology - study of the skeletal system

Otalgia - earache or ear pain

Otitis - inflammation of the ear

Otologist - specialist in treating ear disorders

Ovulation - when a mature egg cell is released into the fallopian tube

Ovum - female sex cell

Oxidation - the combination of a substance with oxygen

Oxygen - a colorless, odorless gas that is essential for breathing

Pallor - paleness

Pancreatectomy - surgical removal of the pancreas

Pancreatic - pertaining to the pancreas

Pancreatitis - inflammation of the pancreas

Paranoia - suspiciousness inappropriate to reality - individual feels that everyone is picking on him/her or out to get him/her

Parasitic organism - one which uses living organic material as a source of food

Parenteral - means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions

Passive range of motion exercises - movements carried out by the staff routinely to prevent complications

Passive immunity - acquired by receiving antibody from a source other than one's own body - e.g. vaccines given for various communicable diseases

Pathogenic organism - one which produces disease

Pathogens - microbes that cause disease

Patient - this terms is usually used when referring to individuals receiving health care in an acute care facility

Peri care - cleaning the genital and anal areas; part of bath or shower procedure or a separate procedure

Pericardium - membrane sac that surrounds the heart

Perineal area - same as genital area

Perineal - the genital and anal areas

Peristalsis - progressive wave of contraction in a tubular structure provided with longitudinal and transverse muscular fibers, as in the esophagus, stomach, and small and large intestines

Perpetrator - person who inflicts harm

pH - the degree to which a solution is acidic or basic

Phagocytosis - ingestion and digestion of microbes by neutrophils and monocytes (part of white blood cells)

Pharyngitis - inflammation of the pharynx

Physical - relating to the body and the functioning of the body

Physiology - study of the functions of the body parts and how they function to form a complete living organism

Pivot joint - those with an extension rotating in a second arch-shaped bone; Ex. radius and ulna

Placenta - fetal membrane that attaches the fetus to the uterus and exchanges nutrients between the mother and fetus

Plaque - sticky, transparent bacterial film found on the teeth

Plasma - liquid part of blood

Pleuritis - inflammation of the pleura

Pneumonitis - inflammation of the lung

Pneumothorax - lung collapses due to a build up of air in the pleura cavity

Poliomyelitis - inflammation of the gray matter of the spinal cord

Polycythemia - bone marrow produces an excess of red blood cells

Polydipsia - excessive thirst

Polyuria - excessive secretion of urine

Portal of entry - pathway by which a microorganism enter the body

Portal of exit - route by which organisms leave the body

Posterior - towards the back

Postmortem - after death

Prepuce - foreskin of male penis

Presumptive - something presumed as true

Privileged communication - any personal or private information which is relevant to a client's care, given by the client to medical personnel

Problem - needs that a client cannot meet by himself/herself

Proctologist - specialist in the diagnosis and treatment of rectal disorders

Proctoscopy - examination of the rectum by the use of a proctoscope

Projectile vomiting - vomitus forcibly ejected without nausea

Pronation - to turn downward; Ex. rotation of the forearm so that the palm of the hand is turned downward

Protoplasm - living substance of all cells

Protozoa - one-celled animals

Psychological - associated with the thought processes of the brain

Psychosomatic - pertaining to the mind body relationship

Pubic - the area of the external genitalia covered with hair

Pulmonary - referring to the lungs

Pulse - alternating expansion and contraction of an artery as blood flows through it

Pulse rate - the number of heartbeats or pulses felt in one minute

Pus - thick yellowish secretion formed in certain kinds of inflammation

Pyelitis - inflammation of the pelvis of the kidney

Pyuria - the presence of pus in the urine

Reality orientation - techniques used to assist a person to become aware of the world in which he/she lives

Receptor - sensory nerve that receives a stimulation and transmits it to the central nervous system

Recording - charting of our observations on the client's charts

Rehabilitation - restoring of an ill or injured client so he/she would be able to help himself/herself

Renal fascia - a tough, fibrous tissue that covers the adipose capsule

Renal pelvis - funnel-shaped structure located at the upper end of each ureter

Renal colic - pain caused by passing a kidney stone

Renal calculi - kidney stones

Reporting - verbal report of care and observations to another nurse

Resident - this term is usually used when referring to individuals receiving health care in a long-term care facility

Residential care facility I - provides shelter and board and may include storage and distribution of medications

Residential care facility II - provides shelter and board; includes storage and distribution of medications, supervision of diet, and assistance with personal care; may include care during short-term illness and recuperation

Residue - what remains of something after a part is removed

Resistance - ability to fight off

Respirations - act of breathing in and out of the lungs (inhalation/exhalation)

Responsible party - a family member/friend of the client who has been designated in writing by the client to handle matters and receive reports related to the client's general condition

Restorative - returning a client to health or consciousness

Retention catheter - a Foley or indwelling catheter

Rhinitis - inflammation of the mucous membrane of the nose

Rigor mortis - temporary rigidity of muscles of the body occurring after death

Rotation - to move a joint in a circular motion

Roughage - indigestible fiber of fruits, vegetables, and cereal which acts as a stimulus to aid intestinal peristalsis

Saliva (spit) - a clear, thin substance produced by the salivary glands in the mouth

Salpingitis - inflammation of the uterine tube

Salpingo-oophorectomy - excision of the ovary and the uterine tube

Sarcoma - tumor of fleshy or connective tissue

Scrotum - the pouch containing the testicles

Secrete - to produce and expel a special substance

Secretion - the expulsion of material which has been chemically modified by a cell to serve a purpose in another body process

Seizure - sudden, periodic attacks of muscles contracting and relaxing

Self care - activities which the client performs

Semen - fluid secreted by the male testes; a male reproductive cell produced in the testes which is capable of uniting with an ovum and developing a new organism

Seropositive - antibodies to HIV appear in the blood stream.

Signs - objective data

Sinoatrial node - conduction system located at the junction of the superior vena cava and right atrium (Purkinje fibers)

Sitz bath - immersing the pelvic area in warm water for 20 minutes

Skeletal muscle - muscles attached to a bone or bones of the skeleton; aids body movement; a form of voluntary (striated) muscle

Skilled nursing facility - facility that has a licensed nurse on duty to provide or supervise care of clients in long-term care as prescribed by the physician; director of nursing is an RN; an RN is on duty during day shift; an LPN or RN is on duty evening or night shift; an RN must be on call when an LPN is on duty

Slander - to make any oral defamatory false remark about another, spoken words that tend to damage the reputation of another

Slang - nonstandard vocabulary used and understood by a small group of people. Slang is often considered incorrect and sloppy

Social - relating to human society, getting along with others

Social services designee - social services representative who is appointed by the resident in writing to take certain responsibilities and receive reports related to a resident's personal possessions and property

Spermatozoon or sperm - male sex cell; spermatozoa is plural form of spermatozoon

Spermicide - an agent that is destructive to spermatozoa

Sphincter - circular muscle - example: anus

Sphincter muscles - a circle of muscle fibers around the outlet of the urethra and rectum which are normally closed but can be relaxed to allow passage of urine and stool

Sphygmomanometer - instrument used to measure BP that consists of a cuff which is applied to the upper arm, and a measuring device

Splanchnology - study of the digestive, reproductive, urinary, and respiratory systems

Sprain - injury to a ligament

Sputum - mucous secretions expelled from the lungs, bronchi, and trachea

Stand-by assist - client requires supervision and/or verbal cues to complete activity (may not always be done safely or correctly)

Sterile - absence of microorganisms

Sterilization - special procedure to destroy all microorganisms

Stertorous respiration - abnormal snoring noises when breathing

Stethoscope - instrument used to listen to the sounds produced by the heart, lungs, and other body organs

Subjective data - signs and symptoms that cannot be observed by seeing, hearing, touching, and smelling; that which is reported by the client

Sundowning - phenomena when behavior problems become worse in evening

Supination - to be bent upward, turn palm of hand up

Supine - lying on one's back

Suppository - a semisolid substance that may contain medicine that dissolves when inserted into the rectum or vagina

Surgical asepsis - sterilization; total absence of bacteria from an area (sterile technique)

Synarthrosis - immoveable joint

Synovial - joint cavity

Systole - active phase of heart contraction

Systolic blood pressure - pressure at the moment of contraction

Systolic pressure - amount of force it takes to pump blood out of the heart into the arterial circulation

Tachycardia - abnormally fast heart beat

Tachypnea - very fast respirations

Temporomandibular joint - connects the upper and lower jaw

Tendon - fibrous cords which connect muscles to bones

Testosterone - male masculinizing hormone

Thoracentesis - procedure to drain excessive fluid from the pleural cavity

Thrombocyte - a clotting cell

Thyrocele - a tumor of the thyroid gland; a goiter

Thyropenia - decreased or deficient activity of the thyroid

Toxin - a poisonous substance

Tracheotomy - incision into the trachea

Transfers - methods of moving a client from one surface to another

Transmitted - transferred or spread

Tubercle - walled off area

Tubercle bacilli - term often used to refer to *Mycobacterium tuberculosis* (and to *Mycobacterium bovis*)

Unable - client cannot ambulate because of necessary strength or mental capability to perform any part of the activity

Unconscious - an individual's lacking in awareness

Ureters - tubes that carry urine from kidneys to urinary bladder

Urethra - the small passage from the bladder through which urine leaves the body

Urinary suppression - kidneys do not produce any urine but the bladder retains the ability to empty

Urinary retention - no urine is voided

Urinary meatus - opening of the urethra on the body surface through which urine is discharged

Urinary catheter - a sterile tube inserted into the bladder to drain urine

Urinate - to pass urine (void)

Urine specimen - a sample of urine taken from the client for laboratory evaluation

Value system - behavior related to a pattern of conduct or ideas that are accepted as worthwhile or meaningful

Valve - a structure that allows the flow of blood or fluid in only one direction

Vasectomy - surgical removal of a section of the vas deferens; each of the separate ends of the vas deferens are tied off

Vector - anything animate or inanimate which carries microorganisms

Vein - a vessel which carries blood to the heart

Ventilate - give air to

Ventricle - the two lower chambers of the heart

Venules - tiny veins

Verbal communication - messages transmitted through the use of spoken words

Vertebral discs - discs of the spinal column down the middle of the back

Virulence - the disease-producing power of an organism

Virus - smallest of all microorganisms

Viscera - internal organs

Visual acuity - the relative ability of the eye to see details clearly

Vital signs - temperature, pulse, respirations, and blood pressure

Void - to pass urine

Voluntary - under control of will

Wandering - aimless walking, which may result in a client becoming lost

White muscle - skeletal muscle that appears paler in flesh than red muscle

Zygote - fertilized ovum